Creation and Validation of a Scale to Measure the Reluctance to Video Record Individual Dialectical Behavior Therapy (DBT) sessions

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Dedication

"We behold what we are, and we are what we behold."

~ Ved Vyasa, The Bhagavad Gita

Abstract

This study created a scale, using exploratory factor analysis (EFA), to examine the reluctance to video record individual Dialectical Behavior Therapy (DBT) sessions. The purpose of this study was to investigate the reluctance of DBT providers to video record individual DBT sessions. Certified DBT providers in the state of Minnesota (N = 286) were surveyed. The response rate was 65%, with n = 186 individuals responding. The 29-item survey consisted of a 21-item scale assessing reluctance to video record DBT sessions, 7 clinician characteristics, and 1 qualitative question. The qualitative question asked: What additional factors, if any, contribute to your reluctance to video record DBT sessions?

Data was analyzed using EFA; principal components analysis using an orthogonal rotation resulted in the identification of four factors, comprised of 18 observed variables. One factor and five observed variables were dropped due to problems with internal consistency and poor factor loadings. The final scale resulted in three factors, comprised of 16 observed variables, accounting for 40.40% of the cumulative variance. The three factors were: Clinicians' Self-Image Concerns, Motivation Concerns, and Client Privacy Concerns.

For the clinician characteristics, MANOVA tests were conducted to assess the effects on the identified scales. Each participant received a score on each of the three respective scales where the scale score was an average of the participant's responses to the observed variables that comprised a particular scale. Higher scores on a scale were

indicative of more reluctance to video record sessions with respect to the concerns or issues represented by the items that comprised a particular scale.

Results of the MANOVA indicated two clinician characteristics yielded statistically significant mean differences. One of the two statistically significant clinician characteristics was: Have you previously recorded your individual DBT sessions? T-tests indicated statistically significant differences between means for the Clinicians' Self-Image scale, [$t(184) = 3.88$, $p < .001$], and the Client Privacy Concerns scale, [$t(184) = 3.43$, $p < .001$]. Specifically, both scales resulted in higher means for individuals who had not previously video recorded individual DBT therapy sessions.

The second clinician characteristic was: With what frequency do you currently video record your individual DBT sessions? T-tests resulted in statistically significant differences between means for the first scale [$t(184) = -2.80$, $p = .006$], Clinician's Self-Image Concerns. Specifically, the scale mean was higher for participants who video recorded DBT sessions less than 20 percent of the time.

Qualitative data provided supplemental information about additional factors contributing to the reluctance to video record DBT sessions, including time, technology, and cost of video recording equipment. Recommendations and results are discussed in the context of existing literature, future areas of research, and contributions of this study to the field of counseling.

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Chapter 1: Introduction

Kurtz and colleagues (2005) depicted video feedback as the "gold standard of communication teaching" (p. 85). To date, video feedback has been used by teachers, doctors, social workers, psychologists, and nurses (Huhra, Yamokoski-Maynhart, & Prieto, 2008; Fukkink, Trienekens, & Kramer, 2011). The use of video recording has brought about positive change in areas such as medicine, where lack of standardized service delivery of evidenced-based practices is well known (Makary, 2013). Smith, Saunders, Stuckhardt, and McGinnis (2012) cite the 2012 Institute of Medicine Best Care at Lower Cost Report, which found frivolous medical care may account for as much as $750 billion of US health care expenditures. Medical efficiencies can be reduced by implementing the use of video recording, while inversely increasing transparency and accountability by providers.

Specifically, in the field of counseling and counselor education, video observation has been used as a supplemental educational tool since the 1960s (Abbass, 2004). In counseling, video observation allows for nonverbal and verbal behaviors of the therapist and client to be recorded and reviewed, providing an objective review of therapy sessions (Haggerty & Hilsenroth, 2011). For instance, video observation provides the opportunity to review nonverbal behavior that may convey boredom, restlessness, or seductiveness (Chodoff, 1972). Video observation also affords the opportunity to assess verbal behavior such as tone and repetitive phrases. Video recordings can be of assistance to the therapist in his/her techniques as well as identification of client behaviors and nuances.

Video observation can be used in individual and group formats across the range of professional experiences - from novice trainees to seasoned clinicians.

Video Observation and Dialectical Behavior Therapy

In the case of dialectical behavior therapy (DBT), an evidenced based practice, video observation ensures that therapists are operating within the model and are following pre-established protocols. The National Registry of Evidence-based Programs and Practice (NREPP) identifies DBT as an evidenced-based practice (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). NREPP ratings must meet criteria for Quality of Research (QOD) and Readiness for Dissemination (RFD). QOR is composed of six criteria: reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, and appropriateness of analysis. RFD is comprised of three criteria: availability of implementation materials, availability of training and support resources, and availability of quality assurance procedures. Together the QOR and RFD criteria determine an evidenced based practice (SAMHSA, 2012). DBT was initially conceived for outpatient clinical settings (Linehan, 1993a) and to treat clients with suicidal tendencies (Linehan & Schmidt III, 1995). In 1993, after numerous randomized controlled studies, Marsha Linehan introduced two seminal texts: *Cognitive Behavioral Treatment of Borderline Personality Disorder* (Linehan, 1993a) and *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993b). Her studies substantiated the efficacy of DBT for individuals diagnosed with borderline personality disorder (BPD).

Video observations are helpful in assuring that data based protocols are being used in DBT sessions. In general, during individual therapy sessions, DBT therapists address – in order – life threatening behavior (e.g., self-injury, suicide attempts), therapy interfering behavior (e.g., skipping sessions, not completing homework), and quality-of-life interfering behavior (e.g., substance use, anxiety, and depression disorders) (Linehan, 1993a). Life Threatening Behaviors, Therapy-Interfering Behaviors, and Quality of Life Interfering Behaviors are defined as:

- **Life-threatening behaviors:** Behaviors that could lead to the client's death are targeted, including all forms of suicidal and non-suicidal self-injury, suicidal ideation, suicide communications, and other behaviors engaged in for the purpose of causing bodily harm.
- **Therapy-interfering behaviors:** This includes any behavior that interferes with the client receiving effective treatment. These behaviors can be on the part of the client and/or the therapist, such as coming late to sessions, cancelling appointments, and being non-collaborative in working towards treatment goals. This is defined in psychology as unmotivated behavior (Miller & Rollnick, 2002).
- **Quality-of-life-interfering behaviors:** This category includes any other type of behavior that interferes with clients having a reasonable quality of life, such as mental disorders, relationship problems, and financial or housing crises.

The primary focus of individual therapy is to enhance the client's motivation to change, whereas the focus of group therapy is to enhance the client's capabilities to

change (Linehan, 1993a). Video observation provides evidence to clients, therapists, and programs that DBT services are being delivered according to the prescribed model.

Abbass (2004) mentions that many theoretical orientations have treatment manuals with prescribed guidelines. For example, DBT therapists can use *A Guide to Viewing a DBT Session* (see Appendix A) to assess adherence. The use of video observation provides the opportunity to assess therapist adherence and reorient the therapist to the DBT model.

In Minnesota, to ensure fidelity to the model, the Department of Human Services encourages DBT IOP (Intensive Outpatient Programs) providers to video record DBT sessions, engage in peer review, and utilize supervision for recorded work. In addition, state-certified providers will soon be able to pursue national DBT certification. One of the requisites for national certification includes the submission of three consecutive tapes of a supervised case or skills group. Certified providers in the state of Minnesota must meet the requirements for an adherent DBT IOP as defined by Minnesota Rule 9505.0370 subpart 12 (see Appendix B) and 9505.0372 subpart 10 (see Appendix C). Thus, it is becoming critical for DBT providers to become familiar and comfortable with the use of video recording their sessions.

Definitions. For the purpose of this paper, the terms video observation (VO), video recording (VR) video report, video monitor(ing), video feedback (VF), and video will be used interchangeably.

Mental health practitioners and *mental health professionals* are defined according to Minnesota Rule 9505.0371 subpart 5 (see Appendix D).

Certified Dialectical Behavior Therapy Intensive Outpatient Programs (DBT IOPs) in the state of Minnesota must adhere to the following requirements, as outlined in the Minnesota Health Care Programs (MHCP) manual:

1) DBT programs must provide individual DBT by a qualified member of the certified team for the recommended duration of one hour per week.
2) DBT programs must provide group skills training by qualified members of the certified team for the recommended duration of two and a half to three hours per week.
3) DBT providers must participate in team consultation for the recommended duration of one and a half hours per week.
4) DBT providers must provide phone coaching to clients, as needed.

Significance of the problem. Haggerty and Hilsenroth (2011) cite the importance of video observation, especially with high-risk clients. High-risk clients include individuals who receive DBT and who may be at risk for hospitalization. In inpatient settings, the prevalence of borderline personality disorder (BPD) is approximately 20% (American Psychiatric Association, 2013). The rate of non-suicidal self-injury (NSSI) for individuals diagnosed with BPD is 69% to 80%, with 8% to 10% dying by suicide, which is almost 50 times greater than the lifetime prevalence of suicide in the general population (American Psychiatric Association, 2001).

Ninety-seven percent of individuals diagnosed with BPD "receive outpatient treatment, on average, from 6.1 therapists" (Perry, Herman, van der Kolk, & Hoke, 1990; as cited in Chapman, 2009, p. 347). In outpatient services, the prevalence of BPD is

approximately 8% to 11%. The prevalence of BPD in the general population is approximately 6% (Grant, Chou, Goldstein, Huang, Stinson, Saha, Smith, Dawson, Pulay, Pickering, & Ruan, 2008). The sobering statistics highlight why the issue of video observation is critical to the field of DBT. Given the high risk and intense nature of clients served through DBT, the objective nature of video is arguably more reliable than the limited inaccurate power of memory to ensure adherence and dissemination of quality treatment (Haggerty & Hilsenroth, 2011).

Also, research indicates "persistence with recording and self-review generally results in improved tolerance of the process over the course of 6 to 12 months" (Abbass, 2004, p. 153). Given the observable, prescriptive, and behavioral tenets of DBT, it is naturally suitable for video observation. In addition, the DBT model aligns well with the healthcare movement towards evidenced-based, data driven, and responsible service delivery. The use of video recording is salient in ensuring critical moments in therapy are not overlooked due to the mentally taxing, complex, and severe nature of client problems; in addition, video observation can be used to identify overarching themes.

The significance of this study is to identify the reluctance to video record individual DBT sessions by establishing a scale that measures reluctance to video record, and consequently, informs state-level policies that promote video recording within the field of counseling – specifically, DBT. The purpose of this study was to investigate the reluctance of DBT providers to video record individual DBT sessions by creating a scale measuring reluctance to video record. With the results, the intent is to improve adherence of an observable, measurable therapeutic modality, DBT.

Statement of the problem. In the proposed study, the research question is: Are there a set of inter-correlated factors that describe the latent, conceptual structure of reluctance to video record individual therapy sessions? In addition, seven clinician characteristics were asked:

- How would you rate your current knowledge of individual DBT protocol?
- With what frequency do you currently video record your individual DBT sessions?
- What is your highest educational degree?
- With which gender do you identify?
- How long have you been providing DBT services?
- Have you previously, at any time, video recorded your individual DBT sessions?
- Within which age bracket do you fall?

These characteristics were coded to nominal variables to ensure the de-identification of data. These characteristics were included as a means of further identifying the reluctance patterns.

In the summer of 2014, all certified DBT Intensive Outpatient Program (IOP) providers (N = 286) in Minnesota were invited to participate in this study through an email invitation (Appendix E), which was sent directly to each provider. The invitation included a description of the study, the informed consent form (Appendix F), and the online survey (Appendix G). The response rate was 65%, with n = 186 individuals responding.

Chapter 2: Review of Literature

Literature for this dissertation was researched from the lib.umn.edu database. To date, research about video recording, specifically in counseling is limited and dated. Research from the 1960s and 1970s remains salient in assessing the benefits and limitations of using video observation. Since the ’60s and ’70s, the use of video observation has flourished in various fields, and has reliably demonstrated efficacy. The following research is critiqued to highlight existing gaps and salient findings in the literature regarding video observation, and to provide justification for this study.

Video Observation in Medicine

A study by Aremllino, Hussain, Schilling, Senicola, Eichorn, Dlugacz, and Farber (2012) demonstrated the power of video recording with a relatively simple concept in a simple study. Hand washing rates of workers at Long Island’s North Shore University Hospital were monitored via video recording, after repeated ineffective educational interventions to increase hand washing (Armellino et al., 2012). The primary focus of the study was to demonstrate the power of video recording to correct and reinforce a desired behavior. The study was conducted in a 17-bed medical intensive care unit. Every sink and hand sanitizer dispenser was monitored by a sensor that detected healthcare workers exiting or entering rooms. Sensors and cameras were installed at an approximate cost of $50,000.

Patient privacy was protected as the only view recorded was of the hand sanitizer dispenser and sinks. Data was collected for 16 weeks prior to the start of the study for comparison. Video monitoring without feedback was conducted for 16 weeks. Video

monitoring with feedback was conducted for 91 weeks; feedback was presented continuously through electronic boards in the hallways along with electronic reports, which were sent to supervisors.

Third party auditing was conducted off site in India by 20 observers. Auditors had to maintain a quality audit rating of 97% or higher. Each event was rated as pass, fail, or not evaluable. Data was reported aggregately as to ensure the privacy of workers. All workers signed a contract regarding the expectations of hand hygiene in the workplace.

As a result of video monitoring, hand hygiene compliance increased from 6.5% to 81.6%; however, it should be noted that ongoing feedback was also cited as an additional factor resulting in increased compliance of hand hygiene techniques. Given the high risk for infection when hand hygiene is not properly and consistently utilized, the cost of video monitoring may offset long term medical costs due to non-compliance. As of this study, there is no standardized procedure for hand hygiene performance. Therefore, results are limited to the hospital in this study as the definition of what constitutes a passing hand hygiene event might differ across medical settings (Armellino et al., 2012).

In the field of anesthesia, patients with central venous catheters who had transferred out of the intensive care unit, in Seattle Children's Hospital in Washington, displayed excessive rates of catheter-associated blood stream infections (CABSIs) despite the use of national standards and policies/procedures to mitigate such occurrences. Rampersad and colleagues (2013) conducted a quantitative study, assessing whether "video recordings can be used as a reliable and useful tool for observing and measuring

changes in anesthesia practice" (p. 628). The group targeted for pre- and post-intervention measures was anesthesia providers. The intervention involved educating anesthetic providers on proper countermeasures related to airway management, intravenous (IV) medication administration, and touching clean anesthesia equipment/supplies. It was hypothesized that the intervention would result in an increased number of clean episodes of practice, thereby reducing the number of CABSIs.

Video observation was chosen over the use of a human observer to minimize the Hawthorne effect (Rampersad, 2013). The Hawthorne effect occurs when participants modify their behavior under observation. Participants were able to opt out of being videotaped several weeks before the start of the study. Three of 48 anesthesia providers chose not to be filmed. Cameras were placed in 5 of 12 operating rooms at Seattle Children's Hospital.

Participants did not know whether they were being recorded since they were unable to tell which cameras were operational. Subjects were randomly assigned to a room with or without a camera. Baseline data was collected via cameras, which were left in the rooms for 6 weeks, intermittently recording 42 hours of activity and capturing 21 cases. Post-intervention data was also collected via the same set of cameras, which were left in the room for 6 weeks, intermittently recording 49 hours of activity and capturing 27 cases. Twenty clips for each of the three-targeted countermeasures were captured.

Intra- and inter-rater reliabilities were both utilized to identify differences before and after the intervention phase. Data were considered reliable with an agreement of .75 percent or higher. Data with reliability of .75 or less were reviewed. It was found the

intervention resulted in statistically significant improvement across all three areas. Clean techniques related to improved airway management increased from 43% to 80% (p = 0.004). Clean techniques related to IV management increased from 5% to 78% (p < .001). Lastly, clean techniques for touching clean equipment/supplies increased from 35% to 66% (p = < .001). Rates of CABSIs dropped from 14.1 per 1000 to 9.7 per 1000 during intervention and to 0 per 1000 during post-intervention.

The use of video observation allowed the researchers to assess the implementation of countermeasures. The use of random assignment supports the validity of the findings, and the use of intra-rater reliability, to an extent, minimizes the bias inherent in self-report. This study highlights the importance of ensuring protocol measures are administered and that knowledge is not enough to affect change.

Limitations of this study make it difficult to establish causality; throughout the hospital the number of bloodstream infections (BSIs) decreased. Also, it is assumed when baseline data were collected, the Hawthorne effect remained a factor, as participants increased the number of clean episodes they engaged in before receiving the intervention. At times, participants were observed waving at the camera, assuming it was on. In addition, due to lack of follow-up with providers, the prolonged effect of video observation in reducing CABSIs remains unknown. Participants' previous exposure to the use of video observation was not assessed. Lastly, raters were not blind to whether the clips were pre- or post-intervention; knowledge of whether the clips were pre- or post-intervention may have altered how the raters scored each clip.

Video Observation Using Various Formats

Chodoff (1972) reported his findings regarding video observation used across 3 large government psychiatric hospitals to study approximately 20 residents in various stages of residency: first year, third year, senior year, and post-residency fellows. Dr. Chodoff served as a consultant for all three hospitals. Supervision was provided in a group format on a weekly or biweekly basis. Two formats of video observation were used. One format was the continuous case seminar, in which a single therapist presented the same client over a period of several months. Another format provided all therapists with the opportunity to present their work for a period of two to four sessions, thereby rendering each therapist as both an observer and a presenter.

In two hospitals, a third party recorded sessions in an adjoining room. In the other hospital, the therapist turned the camera—present in the room—on and off. Both video observation techniques have benefits and limitations. Having a third party operate the camera relieves the therapist of the responsibility of taping; however, the client and therapist are exposed to another individual. Having a camera in the room is more intrusive but does not introduce another person into the session.

One client diagnosed with paranoid schizophrenia did not consent to videotaping. Another client was uncomfortable with being video recorded yet allowed videotaping due to the noticeable improvement in service delivery. When questioned, therapists reported benefitting from video observation. Specifically, one therapist was able to identify his double-binding behavior. Double-binding occurs when nonverbal and verbal behaviors are not congruent. In the therapist's case, he frequently would nod his head in agreement

with the client; what he said, however, was not always in alignment with his nonverbal language. Overall, therapists reported they were grateful to observe their work on tape and detect "out-of-awareness primary and responsive non-verbal behavior of their patients" (Chodoff, 1972, p. 822). This study lends support that video recording and reviewing therapy sessions yields extra information that may have otherwise remain unaddressed as the therapist is able to focus on the content of the interaction.

Limitations of this study include the variable frequency of how often supervision was provided, the different formats of case presentation, and the two methods of recording sessions, as none of these factors appear to have been controlled for. Also, self-reporting is subject to response bias, which affects construct validity. Lastly, previous exposure to the use of video observation was not assessed.

Video Observation versus Other Modalities

Given that "second-hand reporting and audiotapes of session materials are often not able to adequately shed light on the non-verbal behavior exhibited by the patient and therapist" (Haggerty & Hilsenroth, 2011, p. 193), Yenawine & Arbuckle (1971) sought to assess the differences, if any, between the use of videotape versus the use of audiotape in counselor education. Fourteen students in counseling practicum, pursuing a master's degree at Boston University's Department of Counseling Education, were randomly split into two groups: those who used audio observation (n = 6) and those who used video observation (n = 7) of their counseling sessions for analysis. Participants were matched on several salient characteristics (i.e., age, sex, marital status, previous professional experience), minimizing between-group differences.

One postdoctoral student served as the supervisor for both groups. The postdoctoral student was concurrently enrolled in a seminar about supervision of student counselors. Yenawine and Arbuckle (1971) reported the postdoctoral student "had little personal experience with the medium of videotape and only vague knowledge of the authors' specific interests" (p. 2). Additional oversight was provided by two randomly selected faculty members. To analyze the data, researchers created a general understanding of the data reported by students. Using a variety of contrasts and comparisons, specific categories were then established based on the students' self-reports. The findings, as reported by the supervisor and group participants, paralleled one another, contributing to the reliability of the findings.

To normalize the practicum course requirements, during the first session, participants were required to pair up with another group member, assume the role of client or counselor, and video or audio record—based on their respective group—a mock session. Results indicated that students in the videotape group initially felt more anxiety than students in the audiotape group; after completing the mock sessions, however, participants in the videotape group reported less anxiety than participants in the audiotape group. Despite the mock interviews, the postdoctoral supervisor noted that the audiotape group continued to be hesitant in their interactions with each other. The openness observed in the videotape group was tentatively attributed to the undeniable, clear picture resulting in the use of videotape; specifically, no verbal and non-verbal behaviors were able to remain hidden from a clinician's awareness. Bringing the counselor's role to central importance, avoidance is negated when the "original interview is recreated" (p. 5).

Also, prior to using video observation with actual clients, participants in the videotape group were reported to possess a greater awareness of what the counseling relationship entailed compared to their counterparts.

On average, students in the videotape group presented considerably more tapes, with all presenting at least one tape. Two members of the audiotape group chose not to present any tapes. Participants in the videotape group reported that it became difficult to sustain interest in viewing videos, especially when participants were presenting videos for a second time. Despite the decreased interest in observing videos, members in the videotape group found the criticism offered to be constructive, a perception diametrically opposite from that of the audiotape group.

Quite importantly, "introducing videotape as a substitute or alternate for audiotape for the purposes of recording and playback increases the likelihood that a counselor-centered focus—as opposed to a client-centered focus—will be maintained in the review and evaluation process" (Yenawine & Arbuckle, 1971, p. 5) due to the ability to relive the situation. This was evident as the focus in the audiotape group was on the client whereas the focus in the videotape group was on the counselor's role and functioning. Self-evaluation was less evident in the audiotape group as well. The supervisor also reported she perceived students in the videotape group as having progressed further professionally compared to those in the audiotape group.

The videotape group was filmed during the 2nd and 12th sessions in three 15-minute increments. The audiotape group was recorded during the 2nd and 13th sessions in three 15-minute increments. This provided all participants with the opportunity to

observe their respective group in process. Participants in the audiotape group reported, more so than during other occasions when using audio feedback, that they observed group members as responding positively to the feedback provided. The fuller representation provided through videotape compared to audiotape was reported to have accounted for the quicker professional growth in the video observation group.

A particular strength of this exploratory study was the random assignment of participants. Also, the use of one supervisor decreased between-group variance. Lastly, since the supervisor was unfamiliar with the topic, response bias was less likely to influence the findings.

As with all studies, limitations exist. For example, students were selected from a preexisting group; therefore, the sample may not be representative of all counseling students. Also, objectivity was limited as findings were based on the observations of one postdoctoral supervisor. It is also possible that experimenter bias influenced the categorization of themes. There is no mention of the validity and reliability of the Counselor Log—the assessment tool specifically created for this study. Lastly, due to scheduling conflicts, some participants reported the use of simulated sessions and not actual client sessions; it is unclear whether participants who were unable to record client sessions were equally distributed across both experimental groups.

Benschoter, Eaton, and Smith (1965) conducted a study with 13 residents-in-training at the Nebraska Psychiatric Institute, assessing the advantages and disadvantages of video observation. This research supports the aforementioned limitations of other forms of observation, including the use of note taking, which is not always complete;

audiotape, which limits recording only to verbal behaviors; and one-way mirrors, which require the subjective observation of another individual. Weekly psychotherapy sessions (about 45 minutes in length) were recorded and viewed in supervision, with the resident-in-training choosing which cases to record. The video review lasted for 1.5 hours. Residents-in-training received supervision through the use of video observation over a period of 1 year, along with other forms of supervision, and were interviewed about the advantage and disadvantages of video observation.

Residents-in-training reported that video observation prevented "retrospective distortion" (Benschoter et al, 1965, p. 1159), removed subjectivity, guided the resident-in-training to attend to his or her nonverbal behavior, promoted self-instruction, allowed for the identification of themes that might otherwise go unnoticed, resulted in the review of specific moments, and provided perspectives from more than one individual. Despite initial anxiety about this technique, all 13 participants favored the use of video observation over other methods of supervision, including note taking, audio recording, and one-way mirrors.

Over time, clinician anxiety subsided after the initial two to three interviews, which paralleled the pattern of patient anxiety. Also, a continuous case seminar format was used where a more experienced therapist provided video of his or her work to facilitate discussion about psychotherapy. This format provided the student with the opportunity to "go and do likewise" and, as mentioned, helped to normalize the concept of videotaping (p. 1161).

In summary, the aforementioned studies have tentatively substantiated the efficacy of video observation. It has been shown that video feedback has the ability to verify adherence to protocols as described by Rampersad et al. (2013). Also, video feedback allows for the observation of incongruent behavior on the therapist's part, as described by Chodoff (1972). Lastly, compared to other methods of observation, such as audiotape, one-way mirrors, and self-report, videotape tends to provide an array of benefits that are unmatched.

Video Observation and Anxiety

Anxiety can interfere with the use of video observation; excessive anxiety may even deter clinicians from utilizing video observation. Patients, however, tend to be less anxious than therapists and to adapt more quickly to the presence of a camera. A clinician's doubt about the camera, however, can permeate therapy sessions and exaggerate a client's emotional state (Haggard et al., 1965).

Friedmann et al. (1978) conducted a study assessing supervisor, supervisee, and client perceptions of video observation. All supervisors and second-year residents at the Adult Psychiatry Outpatient Clinic of the University of Southern California–Los Angeles County Hospital were asked to complete a survey regarding clinical supervision. Twenty-one out of 22 supervisees (95%) and 32 out of 37 supervisors (86%) completed the survey. The survey assessed the supervisors' and supervisees' perceptions of various types of supervision, goals of supervision, and the recording of one therapy session. Prior to this study, only 16% of residents and 40% of supervisors had used videotape in clinical supervision. The majority of participants operated from a psychodynamic

orientation. The most important goals of supervision, identified by supervisors and supervisees, were "teaching therapeutic techniques, teaching psychodynamics, facilitating the growth of residents, and promoting patient care" (p. 1389).

Supervisees were then asked to record one of their sessions and review it in supervision, creating four groups: supervisees who did record (n = 11), supervisees who did not record (n = 10), supervisors who reviewed videotapes (n = 9), and supervisors who did not review videotapes (n = 23). The eleven residents who volunteered to record their sessions obtained client consent. Out of the nine supervisors who reviewed videotapes, two supervisors provided supervision to two residents each. Supervisees and supervisors filled out a modified Mental Status Evaluation regarding clients before and after taping. Sessions were recorded by volunteers; it is unclear whether the volunteers were present in the room during the counseling sessions.

In addition, supervisees also filled out a survey regarding how video observation affected their client, supervision, and themselves. Prior to taping, statistically significant results ($p < .05$) indicated that supervisees who used video observation thought it would help improve their techniques. Unfortunately, after taping, residents found taping to be less helpful in understanding techniques than predicted ($p < .05$). Interestingly, prior to videotaping, it was supervisors who did not participate in videotaping—compared to supervisors who did participate in videotaping—who thought video observation would promote supervisee self-understanding ($p < .05$) and enhance the assessment of the supervisee's clinical ability ($p < .05$).

Supervisors who reviewed videotapes yielded a statistically significant response regarding their confidence in rating clients pre- and post-review of video observation ($p < .01$). Specifically, supervisors were more confident in their ratings after reviewing the videotape. Supervisees did not yield a statistically significant response regarding their confidence in rating clients pre- and post-review of their videotape.

Clients also completed a questionnaire about how they felt after the taped session. The patients did not find the video observation to be disruptive or problematic; this contradicts the statistically significant results yielded from two groups—supervisors who participated in videotaping and supervisees who did not participate in video observation—who, prior to videotaping, believed video observation would interfere with "patient's production of material" (Friedmann et al., 1978, p. 1389). After taping, supervisors who participated in video observation felt it interfered with the clinician's ability to treat clients ($p < .05$).

This study calls into question the notion that video observation creates an artificial environment, as clients reported "they would not have said anything different had the session not been taped" (Friedmann et al., 1978, p. 1390). It should be noted, however, that hypothetical assessments have low correlations with actual behavior, so it is not possible to confirm that participants would or would not have acted differently.

After watching the videotapes, supervisors were more confident in their perception of clients, with three supervisors changing their diagnosis of clients (Friedmann et al.). This supports the notion that supervisors are able to procure a more detailed and accurate picture of clients through the use of video observation. As Chodoff

(1972) stated, in traditional supervision (e.g., self-report), the supervisor is "deprived of a great deal of information about the patient that the therapist has in his possession but cannot communicate fully" (p. 821).

Limitations of this study include the generalizability of findings, as the primary theoretical orientation of the therapists was psychodynamic in nature. Also, though clinicians were assessed on their previous exposure to video observation, it is unknown whether clients were previously exposed to video observation (Friedman et al.).

Several factors may account for the perception that the residents displayed an increase in anxiety, including "that the residents were afraid the supervisor might use the videotape to evaluate the resident, or that the supervisors were inexperienced in deriving maximum educational benefit from videotaping" (Friedmann et al., 1978, p. 1390). This speaks to the importance of clarifying how video observation will be used in supervision and training supervisees on how to make use of it. With proper instruction, clinician anxiety can quickly decrease (Goldberg, 1983). Reiterating Benschoter et al., to ensure supervisees are properly oriented to the use of video observation and to minimize anxiety, supervisors may consider showing videos of their own sessions (Friedman et al.). By showing their work first, supervisors create an open learning environment in which trainees are more likely to participate in video observation. In addition, a clinician's concern about fallibility is normalized, and supervisees can observe therapy in action (Aveline, 1992).

Dent & Preece (2002) conducted a study assessing whether the personal reflection(s) available through real-time video monitoring offset the uncomfortable

personal and professional feelings associated with being recorded. Eleven students pursuing a master's degree in medical education adopted the role of junior medical students, conducting 5-minute clinical intakes. To ensure that students were utilizing novice skills and were not familiar with the topic at hand, a retired dentist acted as a patient consulting with his dentist. Each student was provided with a different history of the patient.

Students were rated in real time by their peers and mentors who used a SEGUE (*S*et the stage, *E*licit information, *G*ive information, *U*nderstand the patient's perspective, and *E*nd the encounter) checklist (Makasoul, 1995, as cited in Dent & Preece, 2002). After the mock interview, students provided their perspective first, and then received feedback from peers and tutors. Participants also completed an evaluation of what it was like to participate in the study. Overall, participants felt that their anxiety proved to be a catalyst, encouraging them to be more cognizant of their thoughts. Participants did not find the video observation to be intrusive and forgot about the use of video recording once the intake started. Feedback provided by peers and tutors was considered valuable. In this study, participants did not feel the use of role-play created an artificial environment, providing further support that the presence of a video camera does not necessarily alter or inhibit therapy sessions (Dent & Preece).

As with the other studies cited thus far, a small sample size limits the generalizability of findings. Also, though measures were taken to ensure the situation felt novel, it is unclear whether students had previous experience with the use of video

observation and, consequently, may have been desensitized to the presence of a camera. Lastly, the validity and reliability of the SEGUE checklist were not provided.

Fukkink and colleagues (2011) conducted a meta-analysis regarding the use of video feedback (VF) across professions. The analyzed studies were published between 1973 and 2009. To be included in the study, three inclusionary criteria had to be met. First, both the therapist and client had to be visible in the video recording. Second, feedback had to be provided independent of the clinician and client's feedback, and include the use of an observation instrument. Lastly, each study had to report quantitative data that could yield an effect size. Out of the 33 experimental studies, the most frequently used design was pre- and post-test measures. Additionally, only half of the studies used random assignment in their design.

Characteristic codes for each study included nominal and interval variables and: the content of the intervention, the sample population, and the methodological characteristics. Nominal variables were measured using Cohen's kappa and interval variables were measured using the intra-class correlation coefficient (ICC). Variables determined to have reliability less than .70, as measured by two inter-rater responses, were excluded.

Intervention characteristics included the use of additional instruction besides video feedback (VF). The sample population was characterized according to three levels of experience: less than one year practical experience (Level 1, $n = 39\%$), more than 1 year practical experience, including completion of internship (Level 2, $n = 12\%$), and working as a professional (Level 3, $n = 49\%$). Additional factors assessed included the

age, current training, and student status (undergraduate or graduate). Fifty-eight percent of participants were in some form of vocational training and 42% were using video feedback as part of a refresher course. Methodological characteristics included randomization and use of control groups.

Two questions were proposed: 1) What is the effect of VF interventions on the interaction skills of professionals? 2) Which methodological and pedagogical characteristics correlate systematically with the results of experiment studies into VF? Three hypotheses were outlined: First, it was hypothesized video observation would be more efficacious in conjunction with other instructional modalities. Second, it was hypothesized that a structured observation form would be more effective than feedback without a form. Lastly, it was hypothesized that the experimental effects of video feedback would be smaller for seasoned clinicians.

Hedge's *g* was used to determine the effect size, given its ability to correct for bias with small samples. Data was analyzed using a multi-level random effects model, using the restricted maximum likelihood (REML) approach. Multi-level random effects model are best suited for heterogeneous variables. A subsequent hierarchical regression analysis was conducted to assess if results were moderated by the study characteristics. Variables included in the regression analysis were methodological and intervention characteristics. Methodological characteristics were shown to have a statistically significant correlation with the study results, showing the effect sizes are larger for positive outcome measures. Positive outcomes were defined as "desired target behaviors that a professional should display or should display more often" (p. 54). Behaviors were

also categorized into molar or micro measures. Compared to micro measures, effects were larger when molar outcomes were measured.

In response to the first question, interaction skills were grouped into three categories: verbal, non-verbal, and paralingual domains – results indicated moderate effect sizes of .42, .35, and .39, respectively. The effect sizes indicated that verbal behaviors are more easily influenced than non-verbal and paralingual domains. Also, the verbal domain was the only effect size to yield a statistically significant effect. Receptive, informational, and relational skills were found to yield effect sizes of .44, .47, and .35, respectively. The effect sizes indicated informational skills are more easily influenced than receptive and relational skills.

For the first hypothesis, results indicated the use of additional instruction was no more effective than programs that did not use additional instruction ($\beta = 0.13$). For the second hypothesis, results indicated a statistically significant effect size when a structured observation form was used (ES = 0.55), compared to the use of no form (ES = 0.21). Lastly, results indicated no difference between a participant's learning and professional status. The effects of video observation did not decline for more experienced clinicians.

A total of 217 experimental comparisons from 33 experimental studies, consisting of 1,058 people yielded a .40 effect size ($SE = 0.07$). The moderate effect size demonstrated a statistically significant positive effect of video feedback. This study (Fukkink, 2011) is able to provide direction for future research and provides evidence that video observation is beneficial in changing certain behaviors, especially positive behaviors. The reliability of findings, however, is limited given only 217 events were

analyzed. Also, one number cannot summarize an entire research field so the findings of this meta-analysis should be interpreted cautiously.

General Study Limitations

One limitation, present in all the aforementioned studies, includes lack of ethnic or gender identification of participants. A homogenized set of participants would not promote the generalization of findings. Also, while in some studies previous exposure to video observation was identified on behalf of the counselors, none of the studies identified whether the clients had previous exposure to video observation. Some of the studies, conducted in the 1960s and 1970s, lacked contextual detail, which weakened the validity of the findings. In all the studies, selection of participants appeared to be based on preexisting groups, rather than random selection and assignment of participants, also limiting the generalizability of findings.

Considerations for Using Video Observation

Some experts do not consider the use of video observation appropriate for all types of psychotherapy (Aveline, 1992). For instance, the objective nature of video observation may be considered antithetical to the free-flowing, unconscious processes inherent in psychodynamic therapy. In psychodynamic therapy, the focus is usually on the parallel processes of transference and countertransference present in the therapist-client and supervisor-supervisee relationships (Aveline, 1992). Goldberg (1983), however, cautioned against the notion that video observation is incongruent with certain therapeutic orientations. In the case of psychodynamic theory, one of the primary

criticisms has been the lack of empirical data to support the validity of Freud's widely held concepts (Haggard, Hiken, & Isaacs, 1965). Video observation can provide invaluable data to substantiate the efficacy of a particular theoretical orientation, such as psychodynamic therapy.

Aveline (1992) stated that video observation should not be used as a sole instrument for evaluating clinicians and should be used judiciously. Goldberg (1983) recommended viewing video observation as a tool that provides complementary data. For example, Abbass (2004) recommended, in addition to the use of video observation in small groups, conducting psycho-educational seminars regarding the principles of video observation should be discussed. Small group formats are also advantageous, compared to individual supervision, given the ability to reach more trainees using fewer resources (Abbass).

As a supervisory tool, depending on the focus (patient-centered or student-centered), the importance of video observation can vary. From a patient-centered perspective, the focus of video observation is on the client's welfare, making video observation highly relevant. Chodoff (1972) reported that through video observation, the supervisor is privy to dynamics such as client appearance and nonverbal behavior that otherwise remain unassessed in supervision.

Chodoff further states that from a student-centered perspective, video observation may not be considered as relevant since the focus of the sessions is on the supervisor-supervisee relationship. In student-centered supervision, two factors reduce the importance traditionally placed on video observation. First, it is assumed that supervisees

will provide an accurate report of what transpired in session. Second, it is presumed that supervisors will be able to identify any gaps in the supervisee's reporting. However, regardless of the supervision model utilized, supervisees are susceptible to conscious or unconscious misreporting (Friedmann, Yamamoto, Wolkon, & Davis, 1978). Thus, video observation can be a valuable tool in supervision.

Generally, in supervision, video observation has been shown to encourage and improve supervisee self-analysis and provide an objective method for evaluation by the supervisor (Huhra et al., 2008). Video observation can be essential in the skill development of student counselors. For instance, students' impressions of their skills can be verified or enhanced through video observation. The use of video observation in training should be predicated on a supervision plan that outlines its utility (Goldberg, 1983). Since it is not feasible to watch entire sessions in supervision, it is incumbent on the supervisor to achieve a balance between specific moments and overall themes (Chodoff, 1972). Therefore, the effective use of video observation also depends on the supervisor's competency to use it as a learning tool in supervision.

The use of video observation is also contingent on client consent. Some clients may refuse treatment involving the use of video observation; accordingly, client autonomy must be respected (Abbass, 2004). During the course of treatment, if a client withdraws consent for recording at any time, services should not be withheld. At times, video recording of sessions may even be contraindicated with certain clients, such as those with extreme anxiety, active psychosis, paranoia, and non-persecutory delusions. Consent forms should always be utilized specifying "the purpose of the recordings, how

confidentiality will be protected, how long and where the videos will be kept, whether patients have access to their tapes, and who has ownership of the tapes" (Abbass, p. 153).

When assessing non-verbal and verbal behavior in clinical research and treatment, client privacy requires additional attention when traditional methods of ensuring privacy may not be viable. For example, blurring out a client's face in a therapy session may not be feasible, given the consequent inability to assess non-verbal expressions and paint a holistic picture of the counseling session (Broyles, Tate, & Happ, 2008). Guidelines are needed to ensure the appropriate use of video observation. Goldberg (1983) identified three basic principles to adhere to when using video observation:

> *1) Introducing video early in therapy and using it over a period of time*
>
> *2) Educating teachers and students about methods of using video in supervision*
>
> *3) Having a simple setup with stable equipment and no one else present in the room* (p. 1173).

Additionally, Abbass (2004) stated that video review should start with the first point of contact between the therapist and client. According to Abbass, feedback should emphasize the "therapist's functioning within a particular treatment model" (p. 152). Typically, professionals and trainees should review the recording before feedback is given, summarize the overall session, and identify highlights (Abbass).

Video observation provides an opportunity to reflect on the use of micro-behaviors, which are observable behaviors of short duration that can be measured, such as head nods. It further allows for the measure of behavioral constructs such as warmth and engagement, known as molar behaviors (Fukkink et al.).

Benefits of Video Observation

Schacter (1999), supporting the inaccuracy of self-report, has identified seven sins of memory—four of which are particularly relevant to counseling and video observation. First, *transience* is the inability to remember and access information over time. Sometimes, supervision may not occur for up to a week after a session, rendering the memory of the clinician inaccurate. Inaccurate representation of a case could potentially steer the course of therapy down an ineffective or counter-therapeutic path. Transience may be especially prevalent when the need to balance the busy schedules of both the supervisor and supervisee results in greater delays of reviewing a session.

Second, *absent-mindedness* is the inability of a clinician to effectively process various dynamics that occur in an hour-long session. For example, absent-mindedness may occur in emotionally laden sessions. This phenomenon is especially of concern in DBT, given the high level of emotional dysregulation many clients exhibit. Subtle nuances and phrases may be obscured, which can be brought to light via video observation.

Third, *misattribution* occurs when a therapist mixes up what clients have said. Misattribution is likely to occur with clinicians, such as DBT providers, who have a heavy case load comprised of clients with similar presenting problems. The only means to objectively and accurately know what a client has said are video or audio observations.

Lastly, *bias* is the unconscious tendency to influence how information is recalled (Schacter, 1999). Bias can be influenced by a variety of factors, including impression

management. Video observation can mitigate the influence of bias by providing a factual review of sessions.

Levenson (2006, as cited in Haggerty & Hilsenroth, 2011) cited additional benefits of video observation, including stop-frame techniques and the application of theoretical concepts through the use of actual client situations. With stop-frame techniques, the therapist can pause a counseling session and deconstruct what may have otherwise been overlooked in therapy. Utilizing actual client situations in supervision tends to increase the likelihood of implicit learning and retention of skills by the novice therapist.

Limitations of Video Observation

Despite its benefits, the use of video observation has drawbacks. Clinicians who fear being exposed as non-adherent to a particular theoretical orientation, such as DBT, may be hesitant to videotape. Such fears could fuel the perception that video observation is a liability rather than an educational tool (Goldberg, 1983; Haggerty & Hilsenroth, 2011), especially with a high-risk population such as those served by DBT. Fear arising from unfamiliarity with the technology and its associated techniques may also prevent clinicians and supervisors from using video observation in training (Goldberg).

Some clinicians—and clients—may find video observation to be intrusive. Concerns exist about the iatrogenic effects on all parties, such as attenuation of therapeutic effects (Goldberg, 1983). Exhibitionistic or voyeuristic tendencies, on the part of either the client or counselor, should also be taken into consideration to ensure that video observation does not occur under exploitative circumstances (Goldberg).

Time is also a negative factor in video observation, as it requires extra effort to procure video recording equipment, set it up, and review video—both individually and in supervision. The number of years of experience the practitioner has in the counseling profession also affects the use of video observation (Goldberg, 1983). Once established, professionals may be neither comfortable with recording their work nor mandated to record sessions. On the other hand, nascent professionals may be mandated to record their work per agency requirements; in addition, many counseling programs have adopted the use of video observation as part of course requisites. Given their exposure to the use of video observation in an educational setting, newer professionals may be more comfortable engaging in video review of their work. Moreover, research has indicated that the effects of video feedback are greatest in the beginning stages of training and steadily decrease the longer one has been in the field (Fukkink et al., 2011; Huhra et al., 2008). Lastly, cost can be a prohibitive factor. Not all agencies are able to afford current technological video equipment. Abbass (2004) suggested the use of cost-effective technology, when possible, to counter potential financial limitations.

In summary, the research indicates that after initial anxiety decreases, clinicians are able to witness the benefits of video observation, which include professional and personal growth. Video observation provides the opportunity to identify behaviors that may be outside the therapist's realm of consciousness. The most effective use of video observation occurs when all parties are in agreement about the purpose, length, and nature of how video will be used. Though the qualitative nature of the aforementioned

studies possessed several limitations, a certain depth and richness was extracted that might not have been possible through the use of quantitative research.

Dialectical Behavior Therapy

In this section, additional background is provided about DBT, which was developed by Marsha Linehan, PhD, ABPP, in the 1980s (SAMHSA, 2012). DBT is founded on three primary theoretical orientations: biopsychosocial, behavioral, and dialectical philosophies (Rizvi et al., 2013). The biopsychosocial model is predicated on the belief that emotional dysregulation stems from a combination of biological dysfunction and invalidating environments. Emotional dysregulation is defined as "heightened emotional sensitivity, greater emotional reactivity, and a slower return to baseline" (Linehan, 1993a). Cromwell and colleagues (2009, as cited in Rizvi et al., 2013) have also identified the display of impulsivity in early childhood as a factor that increases the predisposition towards emotional dysregulation in adulthood. Emotional dysregulation occurs for many reasons. Primarily, it occurs when a client's thoughts and feelings are not valued. Devaluation occurs when a client's feelings are arbitrarily reinforced. Sometimes a client's feelings are not reinforced until the client engages in high levels of emotional arousal, which may, perhaps unconsciously, send the message that severe emotional expression is necessary to yield a response from others.

Behavioral theory focuses on overt and measurable actions. For the purposes of DBT, the goal is to increase adaptive behaviors and decrease maladaptive behaviors such as nonsuicidal self-injury (NSSI). For example, behavioral interventions for NSSI target intensity, frequency, antecedents, and consequences to provide clients with insight into

their behavior. The focus of treating behavioral targets includes the use of "skills training, contingency management, exposure and cognitive restructuring" (Rizvi et al., 2013, p. 74). By using DBT techniques, the therapist changes which behaviors are reinforced. Successful provision of DBT services is strongest in behaviorally trained therapists (Rizvi et al.).

The primary dialectic in DBT is the ability to balance change and acceptance strategies (SAMHSA, 2012). Dialectics can be used when therapy reaches an impasse. Specifically, using dialectics, the therapist holds on to the polarities of one viewpoint and acknowledges the reality of both sides. Out of the tension that arises from both viewpoints, synthesis can be achieved. Approaching client problems from a dialectical approach helps replace pre-established, rigid ways of thinking.

Modalities of DBT

DBT is comprised of four concepts—individual therapy, skills group, phone coaching, and team consultation—with the five-fold intent to "increase the client's motivation to change, enhance the client's capabilities, generalize the client's gains to his or her larger environment, structure the environment to reinforce the client's gains, and increase therapist motivation and competence" (Rizvi et al., 2013, p. 74). Individual therapy is a principle-based therapy using protocols as needed; skills group is a protocol-based therapy with structured sessions. To complete all four modules of skills-group training requires, on average, 6 months in outpatient treatment. Clients generally complete skills group twice, to reinforce concepts and promote skill generalization (Rizvi et al.).

Phone coaching is available to clients, between sessions, to encourage problem solving and promote skill generalization, but it is not a substitute for individual therapy. The therapist assesses the client's problem with the intent to assist the client in identifying what skills can be used in the moment. Phone coaching should last an average of 5–10 minutes. Clients are prohibited from calling for 24 hours after engaging in self-injurious behavior, to avoid reinforcing maladaptive behavior (Rizvi et al., 2013).

Team consultation plays a vital role in assisting the DBT clinicians who provide individual therapy, skills group, and phone coaching to clients. The primary function of team consultation is to increase the therapist's motivation to provide DBT services effectively and to facilitate adherence (Rizvi et al., 2013). According to SAMHSA (2012), team consultation serves to support, provide consultation to, and reorient clinicians to operate within the DBT model.

For the purpose of this paper, *DBT therapy* is defined as individual therapy (60 minutes per week), skills-group training (2 to 3 hours per week delivered by two trainers), phone coaching (provided as needed), and therapist participation in a 90-minute, weekly team consultation meeting (Minnesota Department of Human Services, 2012).

Through the use of randomized controlled trials (RCTs), DBT has been shown to decrease inpatient hospitalization and the frequency of visits to the emergency room. Additionally, research indicates that DBT treatment results in decreased anger, hopelessness, depression, suicidal ideation, NSSI, and alcohol abuse (Koons et al., 2001; Linehan et al., 1999; Linehan, Armstrong, Suarez, Allmon & Heard, 1991; van den

Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003; all as cited in Rizvi et al., 2013).

Stages of DBT

The five stages of DBT are pretreatment and Stages I to IV (Rizvi et al., 2013). Pretreatment orients clients to the purpose of DBT and results in a commitment from the client to participate in treatment. After pretreatment, a hierarchy of target problem behaviors is identified with the intent to create a life worth living. In Stage I of therapy, the focus is on keeping the client alive and reducing behavioral dysregulation. The targets identified, by importance, are "reducing life threatening behaviors, reducing therapy interfering behaviors, decreasing quality of life interfering behaviors, and increasing behavioral skills" (Rizvi et al., p. 74). In Stage I, a diary card is reviewed at the beginning of each individual therapy session.

Behavioral chains are used with clients to identify what led to a behavior by reviewing the sequence of events. The end result of a behavioral chain is a solution analysis, which refers to interrupting the sequence of actions leading up to maladaptive behaviors as to prevent future occurrences (Rizvi et al.). Stage II addresses "feelings of misery and 'quiet desperation'" (Rizvi et al., p. 75). Stage III focuses on improving a client's quality of life and addressing daily living problems. Stage IV focuses on spirituality and self-awareness. Stages are linear in their presentation, yet clients can progress in a nonlinear fashion.

Limitations of DBT

The majority of research is conducted with women due to the higher rate of diagnosis of BPD in females than males. Also, research is limited in regards to minorities and various ethnic groups. Identifying the active ingredients that cause change for DBT is another limitation. Most of the research conducted about DBT includes the use of the four modalities over a period of 12 months; therefore, without isolating specific components of DBT that facilitate change, it is difficult to speak to what works and does not work (Rizvi et al., 2013). A dialectical approach is beneficial to challenge the existing polarities in psychotherapy that contribute to the benefits and limitations of video observation.

> Student centered versus patient centered, teaching, supervisor-supervisees interactions versus therapist-patient interactions, supervisor as therapists versus supervisor as teacher, manifest versus latent content, content versus process, and teaching how to think versus teaching how to do are all important dimensions in training (Goldberg, 1983, p. 1175).

In team consultation, video observation can be used as a teaching tool for clinicians to learn from one another (Huhra et al., 2008). Also, the use of video observation in team consultation exposes therapists to clients beyond their case load with similar presenting problems; this affords clinicians the opportunity to witness the use of various DBT interventions. Video observation can also provide insight into whether

team consultation is being utilized effectively to treat, support, and motivate the therapist. As Abbass (2004) stated, the use of video observation sets a precedent for "life-long self- and peer-directed learning" (p. 151).

Hypothesis

This writer seeks to obtain empirical evidence, provided the aforementioned research and along with anecdotal information obtained through the Minnesota Department of Human Services, attesting to the reluctance to video record sessions. With the creation of a reluctance scale, it is hypothesized that there are a set of inter-correlated factors that describe the latent, conceptual structure of reluctance to video record individual therapy sessions. After the creation of a reluctance scale, MANOVA tests were conducted to assess the relationship between identified factors and seven clinician characteristics:

- How would you rate your current knowledge of individual DBT protocol?
- With what frequency do you currently video record your individual DBT sessions?
- What is your highest educational degree?
- With which gender do you identify?
- How long have you been providing DBT services?
- Have you previously, at any time, video recorded your individual DBT sessions?
- Within which age bracket do you fall?

Chapter 3: Methodology

This section includes: participants, design, instrumentation, procedure, and analysis. Exploratory factor analysis (EFA) using principal components analysis with a varimax rotation was used to identify factors of the reluctance scale. After establishing a factor structure, a series of exploratory analyses were conducted to assess the relationships between clinician characteristics and each of the identified scales. The effects of seven clinician characteristics were analyzed using Multivariate Analysis of Variance (MANOVA) tests to assess for differences between scale means. Statistically significant MANOVA results were analyzed using post hoc tests.

Participants

After receiving approval from the University of Minnesota Institutional Review Board (IRB), approval for this study was requested from the Minnesota Department of Human Services (DHS) IRB. In both cases, expedited approval was granted. The Adult Mental Health Division (AMHD) of DHS maintains an up-to-date list of contact information for all certified DBT teams and providers. Certified DBT IOP providers were identified as individuals who were enrolled as eligible Minnesota Health Care Program (MHCP) providers and who had obtained the required competencies for a DBT IOP provider as outlined in the Minnesota Healthcare Programs Manual and Minnesota Rule 9505.0370 subpart 12 and 9505.0372 subpart 10 (see Appendices B and C). Required training topics for certification include: Bio-Social Theory and Framework for DBT, Validation, Dialectics, DBT Mindfulness, DBT Consultation Team, and Suicide Risk Assessment/Intervention. Skills trainers must understand and be able to apply

principles of skill Acquisition, Strengthening, and Generalization. Advanced training topics for designated team members may include Exposure Based Procedures, Cognitive Modification, Contingency Management, and Behavioral Analysis. Supervision requirements for DBT IOP providers are defined in Minnesota Rule 9505.0371 subpart 4 (see Appendix H).

As of April 2014, there were 201 mental health professionals and 85 mental health practitioners, including 59 males and 227 females. *Mental health practitioners* and *mental health professionals* are defined according to Minnesota Rule 9505.0371 subpart 5 (see Appendix G). An email invitation (see Appendix B) was sent to all certified Dialectical Behavior Therapy Intensive Outpatient Program (DBT IOP) providers (N = 286) in the state of Minnesota. The email invitation included a description of the study, informed consent, and a link to participate in the online survey. Reminder emails were sent out on a weekly basis, for four weeks. One hundred and eighty six certified DBT IOP providers in the state of Minnesota completed the online survey, resulting in a 65% response rate.

Design

This was an observational study, as no variables were manipulated. The purpose of this study was to investigate the reluctance of DBT providers to video record individual DBT sessions. With the results, the intent was to improve adherence of an observable, measurable therapeutic modality - DBT IOP service delivery. The survey for this study consisted of: 21 items using a 4-point Likert scale, 7 questions assessing clinician characteristics, and 1 qualitative question. The Likert scale was used to assess

factors that may cause reluctance to video record individual DBT sessions; it is a sub-section of the overall survey. Overall, the survey was comprised of 29 questions. The qualitative responses were used to support the identification of distinct factors and to provide a supplementary phenomenological perspective.

Instrumentation

The complete survey is contained in Appendix G. It consists of three parts. First, a reluctance scale was created for this study and is comprised of 21 items. The scale uses a 4-point Likert scale, ranging from 1 *(Completely Non-Reluctant)* to 4 *(Completely Reluctant).* Second, seven clinician characteristics were included in the scale:

- How would you rate your current knowledge of individual DBT protocol?
- With what frequency do you currently video record your individual DBT sessions?
- What is your highest educational degree?
- With which gender do you identify?
- How long have you been providing DBT services?
- Have you previously, at any time, video recorded your individual DBT sessions?
- Within which age bracket do you fall?

For the clinician characteristics questions, participants self-selected into categories based on their current status relative to each question.

Lastly, one open-ended question was included:

- What additional factors, if any, contribute to your reluctance to video record your DBT individual therapy sessions?

The online survey was piloted with three national DBT experts, two state-level policy experts, and one non-certified DBT team applying for state certification. Revisions were made to the format of the survey to ensure item clarity, content readability, accuracy of items, and completeness.

Procedure

To create a scale assessing therapist reluctance to video record individual DBT sessions, knowledge about reluctance to video record individual DBT sessions gathered *a priori* via employment as a mental health program consultant for the Minnesota Department of Human Services – Adult Mental Health Division was utilized. A panel group was utilized to ensure salient activities were identified as appropriate indicators of reluctance to video record individual DBT sessions. The panel group consisted of two non-certified DBT teams applying for certification in Minnesota. The agreed upon items between this researcher and the panel group were built into the reluctance scale, using a 4-point Likert Scale – ranging from 1 *(Completely Non-Reluctant)* to 4 *(Completely Reluctant).*

Analysis

For the reluctance scale, exploratory factor analysis (EFA), specifically – principal components analysis (PCA) with a varimax rotation was used to identify factors. EFA results were used to assess the cumulative variance explained by the scale. No hypothesis was assumed *a priori* about the number of factors comprising the scale, resulting in the use of EFA; the use of EFA is predominant in social sciences (Kim and

Mueller, 1978). Scale factors were labeled based on a common theme. According to Yong and Pearce (2013), "Naming of factors is more of an 'art' as there are no rule for naming factors, except to give names that best represent the variables within the factors" (p. 91).

MANOVA tests were conducted between each scale and the seven clinician characteristics. Post hoc tests were conducted for any statistically significant clinician characteristics to assess for specific differences between scale means. In summary, Chapter 3 included the approval method necessary to execute this study. The design and purpose of the study were also described. In addition, participants and corresponding demographics were provided. Information regarding the instrument used in this study and procedure to create the instrument were discussed. Lastly, methods of analyses were described.

Chapter 4: Results

This section is divided into three parts: EFA results, MANOVA and post hoc tests, and discussion of qualitative responses. The qualitative data is based on participants' written responses to the last survey question: What additional factors, if any, contribute to your reluctance to video record your DBT individual sessions? The qualitative data should be considered non-statistical, supportive information because written responses were interpreted based on a cursory examination of key words. For example, responses referencing reluctance to video recording due to technology concerns and complications were grouped together.

Results of the scale indicated the presence of three factors identified as: Clinicians' Self-Image Concerns, Motivation Concerns, and Client Privacy Concerns. No data was missing when analyzing scale responses. MANOVA tests were used to assess statistically significant differences between clinician characteristics and each scale. Results indicated 2 of the seven clinician characteristics produced statistically significant differences. Post hoc tests were conducted to assess which specific scale means were statistically significant for the respective clinician characteristics. Reverse coding was not needed for any of the items. For the Likert scale, items were coded from 1 (*Completely Non-Reluctant*) to 4 (*Completely Reluctant*).

Exploratory Factor Analysis

Exploratory Factor Analysis (EFA) seeks to find and verify patterns based off of observed variables (Kim & Mueller, 1978). The intent of this initial analysis is to identify distinct constructs, which renders PCA as the better alternative over

Principal Axis Factoring (PAF). In attempts to seek parsimony, PCA was chosen. Also, PCA was chosen in order to maximize the variance of the factors in order to enhance the interpretability. A varimax rotation was chosen as it is meant to simplify data interpretation by loading many observed variables onto a few, discrete factors (Abdi, 2003).

Determining the factors to extract includes the use of heuristics, including but not limited to: eigenvalues, scree plots, matrix rotations, fit indices, and the researcher's best judgment. Comrey and Lee (1992) offer the following guidelines for sample sizes when using factor analysis: 100 = poor, 200 = fair, 300 = good, 500 = very good, 1,000 or more = excellent. In this study, the eigenvalue greater than 1 rule" or the "K – 1 rule" (Kim & Mueller) in conjunction with the scree plot (see Figure 1) indicated the extraction of four factors. In addition, the communalities for the four factor solution are strong (see Table 1).

Figure 1

Scree Plot for Factor Extraction

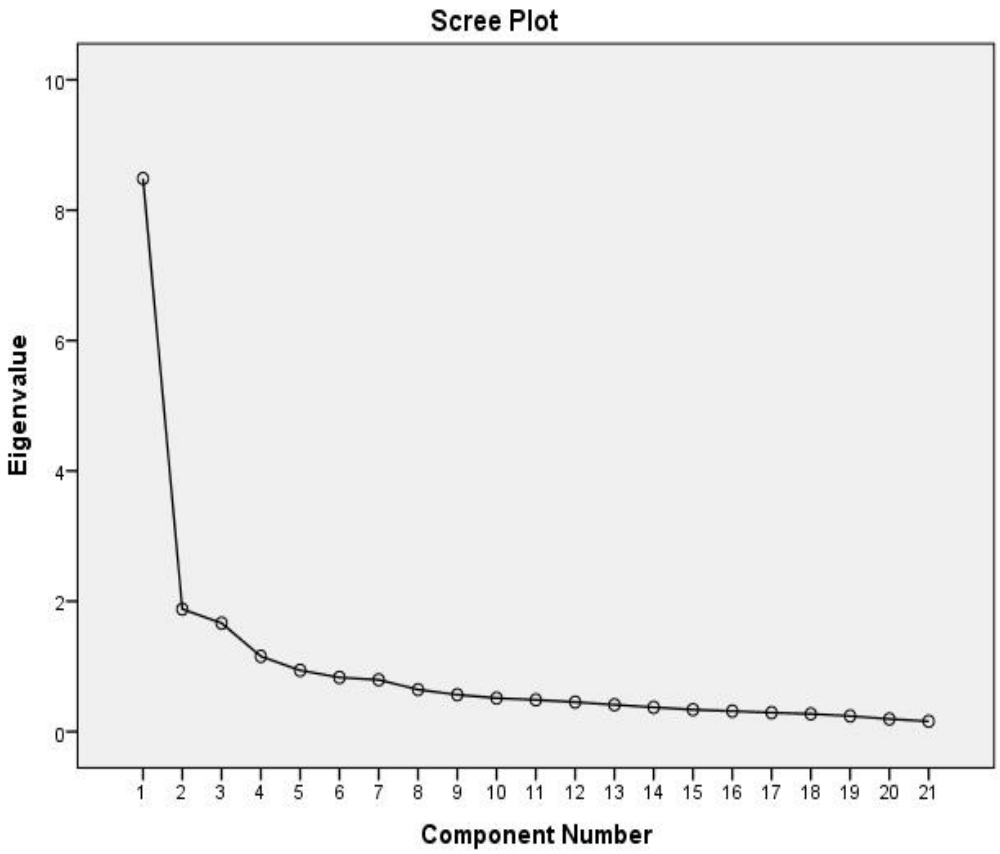

Table 1

Factor Loadings for Exploratory Factor Analysis with Varimax Rotation Plus Communalities

Factors	Clinician Self Talk	Motivation	Client Privacy	Communalities
Your client's primary concern is Serious Quality of Life Interfering Behavior.	.842	.069	.220	.762
Your client's primary concern is Life-Threatening Behaviors (including imminent suicide risk).	.795	.045	.310	.730
Your client's primary concern is Therapy-Interfering Behavior.	.747	.139	.146	.605
You receive feedback you are providing individual DBT according to the model.	.739	.193	.005	.592
You know others on your team are also video recording their sessions.	.733	.210	.083	.677
You observe video recordings of another provider conducting adherent individual DBT.	.675	.358	-.062	.610
You receive additional training, specifically, about individual DBT.	.665	.266	-.028	.570
Your video will be shown to your DBT supervisor.	.558	.465	-.040	.641
You observe video recordings of another provider conducting non-adherent individual DBT.	.546	.398	-.022	.504
You are engaging in Therapy-Interfering Behavior.	.057	.860	.129	.780
You are engaging in Team-Interfering Behavior.	.171	.779	.026	.637
You receive feedback you are not providing individual DBT according to the model.	.314	.706	.120	.626

You are experiencing burnout.	.233	.544	.219	.404
You are concerned about your client's privacy.	.020	.161	.785	.647
You feel your client would be inhibited during therapy.	.227	-.016	.723	.576
Your client has voiced concerns about his or her privacy.	.034	.210	.686	.608

Three variables were dropped because they cross-loaded on more than one factor. These were:

- Your video will be shown in DBT team consultation.
- Your video will be shown to a DBT team member.
- You do not know if others on your team are also video recording their sessions.

One factor was dropped as it was only comprised of two observed items:

- Your video will be shown to your non-DBT supervisor.
- Your video will be shown to a non-DBT team member.

The two items do not afford the ability to construct a scale of which the internal consistency can be determined. Thus, this factor was dropped from further analyses. This factor accounted for 7.93% of the cumulative variance explained by the four factors (see Table 2). The cumulative variance explained is the sum of all eigenvalues in a factor analysis divided by the number of observed variables. Subtracting the variance from the dropped factor, in total, three factors accounted for 54.85% of the cumulative variance. The cumulative variance explained is how well the factors explain the relationship between the observed variables.

Table 2

Exploratory Factor Analysis Variance Statistics: Eigenvalues, Percent of Variance Explained, Sum of Squared Loadings, Rotated Sums of Squared Loadings

Observed Variables	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.485	40.403	40.403	8.485	40.403	40.403	5.491	26.150	26.150
2	1.879	8.945	49.349	1.879	8.945	49.349	3.504	16.688	42.837
3	1.664	7.926	57.275	1.664	7.926	57.275	2.158	10.274	53.111
4	1.155	5.501	62.776	1.155	5.501	62.776	2.030	9.665	62.776
5	.940	4.475	67.251						
6	.830	3.953	71.204						
7	.795	3.786	74.990						
8	.644	3.067	78.057						
9	.566	2.695	80.752						
10	.514	2.446	83.198						
11	.487	2.317	85.515						
12	.453	2.157	87.672						
13	.411	1.958	89.630						
14	.373	1.774	91.404						
15	.337	1.607	93.010						
16	.314	1.497	94.508						
17	.291	1.385	95.893						
18	.271	1.291	97.184						
19	.239	1.137	98.321						
20	.194	.924	99.244						
21	.159	.756	100.000						

Table 3

Tests of Sampling Adequacy and Sphericity

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.903
Bartlett's Test of Sphericity	Approx. Chi-Square	2093.386
	df	210
	p	.000

Fit Indices. Bartlett's Test (see Table 3) provides evidence that the observed correlation matrix is statistically different from the identity matrix. The identity matrix is where all diagonals are 1 and off-diagonals are 0, indicating none of the variables are correlated, rendering the use of factor analysis inappropriate to analyze the data (Jones & Bartlett Publishers, n.d.). For this study, Bartlett's test produced a significant test result, rejecting the null hypothesis and indicating the use of factor analysis was appropriate to analyze the data. The KMO index is a measure of shared variance and is a measure of sampling adequacy (Jones & Bartlett Publishers). For this study, the KMO value of .903, which is considered excellent (see Table 3).

A factor loading cutoff of .40 was chosen; research indicates .40 is considered to be the least stringent and lowest acceptable cutoff (Matsunaga, 2010). Overall, 16 out of 21 items were selected for the scale.

Factor One. The first factor, Clinicians' Self-Image Concerns, accounts for 40.40% of the cumulative variance explained by the three remaining factors. Two variables were removed as they cross load onto the second factor:

- Your video will be shown to a DBT team member.
- You do not know if others on your team are also video recording their sessions.

Cronbach's alpha for the Clinician's Self-Image Concerns scale was .91, which is considered highly reliable. George and Mallery (2003, p. 231) provide the following cutoffs for alpha's Cronbach: ≥ .9: Excellent, ≥ .8: Good, ≥ .7: Acceptable, ≥ .6: Questionable, ≥ .5: Poor, and < .5: Unacceptable. Aside from the aforementioned discarded observed variables, below are the observed variables that loaded onto the Clinicians' Self-Image Concerns factor:

- Your client's primary concern is Serious Quality of Life Interfering Behavior.
- Your client's primary concern is Life-Threatening Behaviors (including imminent suicide risk).
- Your client's primary concern is Therapy-Interfering Behavior.
- You receive feedback you are providing individual DBT according to the model.
- You know others on your team are also video recording their sessions.

- You observe video recordings of another provider conducting adherent individual DBT.
- You receive additional training, specifically, about individual DBT.
- Your video will be shown to your DBT supervisor.
- You observe video recordings of another provider conducting non-adherent individual DBT.

The factor, Clinicians' Self-Image Concerns, is defined as: The client's concerns are very serious, including self-injury. The clinician believes that she is competent in providing DBT, after all she has taken additional training, and has received feedback that she is competent. However, the clinician is concerned because she has seen others conduct DBT in a non-competent manner and that, if viewed by the supervisor, she will be seen as not competent either.

Factor Two. The second factor, Motivation Concerns, accounts for 8.95% of the cumulative variance explained by the three factors. Cronbach's alpha for the Motivation Concerns factor was .79, which is considered highly reliable (George & Mallery). Below are the observed variables that loaded onto the Motivation Concerns factor.

- You are engaging in Therapy-Interfering Behavior.
- You are engaging in Team-Interfering Behavior.
- You receive feedback you are not providing individual DBT according to the model.
- You are experiencing burnout .

The factor, Motivation Concerns, is defined as: The therapists are not motivated and DBT teams are not exhibiting behavior indicating team members are motivated either. Therapists feel that they are not conducting DBT competently and are experiencing burn out.

Factor three. The third factor, Client Privacy Concerns, accounts for 5.50% of the cumulative variance explained by the three factors. Cronbach's alpha for the Client Privacy Concerns factor was .68, which is considered close to an acceptable internal consistency value (George & Mallery). The following variables loaded onto the Client Privacy Concerns factor.

- Your video will be shown to your non-DBT supervisor.
- Your video will be shown to a non-DBT team member.
- You are concerned about your client's privacy.
- You feel your client would be inhibited during therapy.
- Your client has voiced concerns about his or her privacy.

The factor, Client Privacy Concerns, is defined as: The clinician is concerned about the client's privacy and feels the client would be inhibited in therapy. Additionally, the client has expressed concerns about privacy.

Table 4 provides factors mean and standard deviations for each of the three factors as well as the summary scale, which includes the 16 observed variables resulting in the three factors. Higher score means are indicative of more reluctance to video record and lower score means are indicative of less reluctance to video record. Results indicate Factor 3, Client Privacy Concerns, yielded the highest reluctance to video record

individual DBT therapy sessions. Factor 1, Clinicians' Self-Image Concerns, indicated the least reluctance to video record individual DBT therapy sessions.

Table 4

Factor and Summary Scale Descriptive Statistics

Factors	*M (SD)*
Clinician's Self Image Concerns	2.0 (.79)
Motivation	2.5 (.77)
Client Privacy	3.1 (.64)
Summary Scale	2.4 (.61)

MANOVA results. The relationship between seven clinician characteristics and each of the factors was assessed using MANOVA tests. Primarily, the sample was comprised of: master's level professionals (78.5%), females (84.4%), and providers who rated their current knowledge of individual DBT protocol as "knowledgeable" (72.6%). A staggering 91.9% of participants reported video recording only 0% to 19 % of the time despite 51.16% endorsing previous experience video recording sessions. 48.39% of participants have provided DBT services for 1 to 5 years. The modal age group for participants was between 41 to 50 years of age (34.9%).

Results of the MANOVA tests indicated 2 of the 7 clinician characteristics were statistically significant for at least one of the dependent variables:

- With what frequency do you currently video record your individual DBT sessions?
- Have you previously video recorded your individual DBT sessions? .

Post hoc results are provided for statistically significant MANOVA findings. Pairwise t-tests were conducted, using a Benjamini and Hochberg adjustment to control for experiment wise error, for the two clinician characteristics.

Below are tables providing descriptive, MANOVA, and post hoc statistics for each clinician characteristic. The level of each clinician characteristic is represented by the categories presented in each respective table. Each clinician characteristic has a table that indicates the original independent variable levels as measured in the survey. For the purpose of statistical analysis, independent variable levels were grouped together based on theoretical appropriateness and to maximize statistical power. Each cell represents the

mean of an independent response variable for each of the three factors. Despite attempts to maximize statistical power, the sample size of particular independent variable level groups remained small. Power is based on the smallest sample size; therefore, even moderate effect sizes may have remained unnoticed due to the unbalanced groups and consequent low power. Unlike significance tests, effect sizes are not influenced by sample size.

Effect sizes, Cohen's *d* and Cohen's *f*, were provided. Cohen's *d* is used to determine effect sizes for two groups. For Cohen's *d*, according to Cohen (1988), an effect size of .2 to .3 is considered small, .5 to .8 is considered medium, and above .8 is considered large. Cohen's *f* is used to determine effect sizes for more than the groups. For Cohen's *f*, effect sizes of .02, .15, and .35 are considered small, medium, and large, respectively (Cohen, 1988).

Each participant received a score on each of the three respective scales where the scale score is an average of the participant's responses to the questionnaire items that comprise a particular scale. Higher scores on a scale are indicative of more reluctance to video record sessions with respect to the concerns or issues represented by the items that comprised a particular scale.

Clinician characteristic: How would you rate your current knowledge of individual DBT protocol? (*N* = 186) The question provided four possible response choices from which the respondent could choose: Extremely Knowledgeable, Knowledgeable, Low Knowledge, and No Knowledge. Table 5 provides the frequency of each response category for the question "How would you rate your current knowledge of individual DBT protocol?" For statistical analysis purposes, two groups were identified: Extremely Knowledgeable and Knowledgeable (*N* = 174) versus Low Knowledge and No Knowledge (*N* = 12). A MANOVA test (see Table 6) indicated no statistically significant relationship between the grouping variable and any of the three scales.

Table 7 provides mean scores for each of the two identified groups on each of the three scales. Results indicated a higher mean on the Clinicians' Self Image Concerns scale for the Low to No Knowledge group. Results also indicated a higher mean on the Motivation Concerns scale for the Low to No Knowledge group. Lastly, results indicated a lower mean on the Client Privacy Concerns scale for the Low to No Knowledge group. Small effect sizes were identified for the Clinicians' Self Image Concerns scale and the Client Privacy Concerns scale, indicating negligible differences between group means. A moderate effect size was detected for the Motivation Concerns scale, indicating a moderate difference between group means.

Table 5

Frequency of each Response to the Question: How would you rate your current knowledge of individual DBT protocol? (N = 186)

	Extremely Knowledgeable	Knowledgeable	Low Knowledge	No Knowledge
N	39	135	11	1

Table 6

MANOVA Results Using the Three Scales as Dependent Variables and Knowledge of Current DBT Protocol as the Grouping Variable

Pillai's Trace	F	*df*	Error *df*	p-value
.03	2.04	3	182	.11

Table 7

Comparison of Mean Scores on each Scale between High and Low Levels of Knowledge of Current DBT Protocol (N = 186)

	Level of Knowledge About DBT		
	Extremely Knowledgeable or Knowledgeable (*N* = 174)	Low Knowledge or No Knowledge (*N* = 12)	
Scales	*M (SD)*	*M (SD)*	Cohen's *d*
Clinicians' Self-Image Concerns	2.02 (.80)	2.10 (.73)	0.11
Motivation Concerns	2.51 (.76)	2.96 (.81)	0.57
Client Privacy Concerns	3.10 (.64)	2.97 (.75)	0.19

Clinician characteristic: With what frequency do you currently video record your individual DBT sessions? (*N* = 186)

The question provided five possible response choices: 0 to 19%, 20 to 39%, 40 to 59%, 60 to 79%, and 80 to 100%. Table 6 provides the frequency of each response category for the question: "With what frequency do you currently video record your individual DBT sessions?" For statistical analysis purposes, two groups were identified: 0 to 19% (*N* = 171) versus 20 to 100% (*N* = 16). A MANOVA test (see Table 8) indicated a statistically significant relationship between the grouping variable and at least one of the three scales.

Table 9 provides mean scores for each of the two identified groups on each of the three scales. Results indicated a higher mean on the Clinicians' Self Image Concerns scale for the 0 to 19% group. Results indicated a lower mean on the Motivation Concerns scale for the 0 to 19% group. Lastly, results indicated a higher mean on the Client Privacy Concerns scale for the 0 to 19% group. Small effect sizes were identified for the Client Privacy Concerns scale and the Motivation Concerns scale, indicating negligible differences between group means. A strong effect size was detected for the Client Privacy Concerns scale (*d* = -0.82), indicating a strong difference between group means. Specifically, the only statistically significant difference was between the group means for the first scale, Clinicians' Self-Image Concerns (see Table 10).

Table 8

Frequency of each Response to the Question: With what frequency do you currently video record your individual DBT sessions? (N = 186)

	0 to 19%	20 to 39%	40 to 59%	60 to 79%	80 to 100%
N	171	9	3	1	2

Table 9

MANOVA Results Using the Three Scales as Dependent Variables and Individual DBT Video Recording Frequency as the Grouping Variable

Pillai's Trace	F	*Df*	Error *df*	p-value
.06	3.90	3	182	.01

Table 10

Pairwise t-test Results for each Scale by Individual DBT Video Recording Frequency Group

Scales	Means		95% CI					
	0 to 19%	20 to 100%	*LL*	*UL*	*t*	*df*	*p*	*Cohen's d*
Clinicians' Self-Image Concerns	2.07	1.49	-1.0	-.17	-2.80	184	0.01	-0.82
Motivation Concerns	2.53	2.55	-.39	0.43	0.08	184	0.94	-0.03
Client Privacy Concerns	3.10	2.98	-.46	.22	-0.70	184	0.48	0.22

Note. CI = confidence interval; *LL* = lower limit, *UL* = upper limit.

Clinician characteristic: What is your highest educational degree with which you conduct individual DBT? (*N* = 184) The question provided four possible response choices from which the respondent could choose: Bachelor's, Master's, Doctorate (PsyD/PhD), and MD. Table 11 provides the frequency of each response category for the question: What is your highest educational degree with which you conduct individual DBT? For statistical analysis purposes, two groups were identified: Bachelor's and Master's (*N* = 146) versus Doctorate and MD (*N* = 38). A MANOVA test (see Table 12) indicated no statistically significant relationship between the grouping variable and any of the three scales.

Table 13 provides mean scores for each of the two identified groups on each of the three scales. Results indicated a higher mean on the Clinicians' Self Image Concerns scale for the Bachelor's and Master's group. Results indicated a higher mean on the Motivation Concerns scale for the Bachelor's and Master's group. Lastly, results indicated a higher mean on the Client Privacy Concerns scale for the Bachelor's and Master's group. Small effect sizes were identified for each of the three scales, Clinicians' Self Image Concerns, Motivation Concerns, and Client Privacy Concerns scale, indicating negligible differences between group means.

Table 11

Frequency of each Response to the Question: What is your highest educational degree with which you conduct individual DBT? (N = 184)

	Bachelor's	Master's	Doctorate (PhD/PsyD)	MD	No Response
N	7	146	30	1	2

Table 12

MANOVA Results Using the Three Scales as Dependent Variables and Highest Educational Degree as the Grouping Variable

Pillai's Trace	F	*Df*	Error *df*	p-value
0.01	.80	3	180	.50

Note. Two participants did not respond.

Table 13

Comparison of Mean Scores on each Scale between Educational Degree Levels (N = 184)

	Bachelor's and Master's (*N* = 146)	Doctorate and MD (*N* = 38)	
Scales	*M (SD)*	*M (SD)*	Cohen's *d*
Clinicians' Self-Image Concerns	1.95 (.78)	2.18 (.89)	0.29
Motivation Concerns	2.40 (.72)	2.50 (.84)	0.13
Client Privacy Concerns	2.90 (.63)	2.91 (.64)	0.02

Note. Two participants did not respond.

Clinician characteristic: With which gender do you identify? (*N* = 186) The question provided three possible response choices from which the respondent could choose: Female, Male, or Transgender. Table 14 provides the frequency of each response category for the question: With which gender do you identify? For statistical analysis purposes, two groups were identified: Female (*N* = 157) versus Male or Transgender (*N* = 29). A MANOVA test (see Table 15) indicated no statistically significant relationship between the grouping variable and any of the three scales.

Table 16 provides mean scores for each of the two identified groups on each of the three scales. Results indicated a higher mean on the Clinicians' Self Image Concerns scale for the Female group. Results indicated a higher mean on the Motivation Concerns scale for the Female group. Lastly, results indicated a higher mean on the Client Privacy Concerns scale for the Female group. Small effect sizes were identified for each of the three scales, Clinicians' Self Image Concerns, Motivation Concerns, and Client Privacy Concerns scale, indicating negligible differences between group means.

Table 14

Frequency of each Response to the Question: With which gender do you identify? (N = 186)

	Female	Male	Transgender
N	157	28	1

Table 15

MANOVA Results Using the Three Scales as Dependent Variables and Gender as the Grouping Variable

Pillai's Trace	F	*Df*	Error *df*	p-value
.017	1.08	3	182	.36

Table 16

Comparison of Mean Scores on each Scale between Gender Levels (N = 186)

Scales	Female (*N* = 157)	Male or Transgender (*N* = 29)	Cohen's *d*
	M (SD)	*M(SD)*	
Clinicians' Self-Image Concerns	2.07 (.78)	1.81 (.82)	-0.32
Motivation	2.55 (.78)	2.47 (.74)	0.11
Client Privacy	3.11 (.63)	2.98 (.70)	0.20

Clinician characteristic: How long have you been providing individual DBT? (*N* = 186).

The question provided five possible response choices from which the respondent could choose: Less than one year, 1 to 5 years, 6 to 10 years, 11 to 15 years, or 16 plus years. Table 17 provides the frequency of each response category for the question: How long have you been providing individual DBT? For statistical analysis purposes, four groups were identified: Less than one year (*N* = 31), 1 to 5 years (*N* = 90), 6 to 10 years (*N* = 39), and 11 or more years (*N* = 26). A MANOVA test (see Table 18) indicated no statistically significant relationship between the grouping variable and any of the three scales.

Table 19 provides mean scores for each of the four identified groups on each of the three scales. Results indicated the highest mean for the Clinicians' Self Image Concerns scale for the Less than one year group. Results indicated the highest mean on the Motivation Concerns scale for the 6 to 10 years group. Lastly, results indicated the highest mean on the Client Privacy Concerns scale for the 1 to 5 years group. Small effect sizes were identified for each of the three scales, Clinicians' Self Image Concerns, Motivation Concerns, and Client Privacy Concerns scale, indicating negligible differences between group means.

Table 17

Frequency of each Response to the Question: How long have you been providing individual DBT? (N = 186)

	Less than one year	1 to 5 years	6 to 10 years	11 to 15 years	16 + years
N	31	90	39	22	4

Table 18

MANOVA Results Using the Three Scales as Dependent Variables and Length of Time Providing DBT as the Grouping Variable

Pillai's Trace	F	*df*	Error *df*	p-value
.038	2.42	3	182	.07

Table 19

Comparison of Mean Scores on each Scale between Length of Time Providing DBT Levels (N = 186)

Scales	Less than one year	1 to 5 years	6 to 10 years	11 or more years	Cohen's *f*
Clinicians' Self-Image Concerns	2.16	2.11	1.91	1.73	.19
Motivation Concerns	2.49	2.51	2.60	2.56	.05
Client Privacy Concerns	3.00	3.18	2.93	3.12	.16
N	31	90	39	26	-

Clinician characteristic: Have you previously video recorded your individual DBT sessions? (*N* = 186)

The question provided two possible response choices: Yes or No. Table 20 provides the frequency of each response category for the question: "Have you previously video recorded your individual DBT sessions?" For statistical analysis purposes, two groups were identified: Yes (*N* = 96) versus No (*N* = 90). A MANOVA test (see Table 21) indicated a statistically significant relationship between the grouping variable and at least one of the three scales.

Table 22 provides mean scores for each of the two identified groups on each of the three scales. Results indicated a higher mean on the Clinicians' Self Image Concerns scale for the No group. Results indicated a higher mean on the Motivation Concerns scale for the No group. Lastly, results indicated a higher mean on the Client Privacy Concerns scale for the No group. Small effect sizes were identified for the Motivations Concerns scale and the Motivation Concerns scale, indicating negligible differences between group means. Moderate effect sizes were detected for the Clinicians' Self Image Concerns scale and the Client Privacy Concerns scale, indicating differences between group means. Specifically, the statistically significant differences were found between the group means for the first scale, Clinicians' Self-Image Concerns and the third scale, Client Privacy Concerns (see Table 23).

Table 20

Frequency of each Response to the Question: Have you previously video recorded your individual DBT sessions? (N = 186)

	No	Yes
N	90	96

Table 21

MANOVA Results Using the Three Scales as Dependent Variables and Previous Video Recording of Individual DBT Sessions as the Grouping Variable

Pillai's Trace	F	*df*	Error *df*	p-value
.13	9.20	3	182	< . 001

Table 22

Comparison of Mean Scores on each Scale between Previously Video Recording DBT Levels (N = 186)

Scales	Yes (*N* = 96)	No (*N* = 90)	Cohen's *d*
	M (SD)	*M (SD)*	
Clinicians' Self-Image Concerns	1.82 (.74)	2.25 (.78)	-0.57
Motivation	2.50 (.79)	2.57 (.76)	-0.09
Client Privacy	2.94 (.66)	3.25 (.59)	-0.50

Table 23

Pairwise t-test Results for each Scale by Previously Video Recording Individual DBT Sessions Frequency Group

	Means		95 CI				
Scales	*Yes*	*No*	*LL*	*UL*	*t*	*df*	*p*
Clinicians' Self-Image Concerns	1.82	2.25	.21	.65	3.88	184	< .001
Motivation	2.50	2.57	-.16	.29	0.59	184	.56
Client Privacy	2.94	3.25	.13	.50	3.43	184	< .001

Note. CI = confidence interval; *LL* = lower limit, *UL* = upper limit.

Clinician characteristic: Within which age bracket do you fall? (*N* = 185)

The question provided six possible response choices from which the respondent could choose: 20 to 30, 31 to 40, 41 to 50, 51 to 60, 61 to 70, and 71 to 80. Table 24 provides the frequency of each response category for the question: Within which age bracket do you fall? For statistical analysis purposes, two groups were identified: 20 to 50 (*N* = 132) versus 51 to 80 (*N* = 53). A MANOVA test (see Table 25) indicated no statistically significant relationship between the grouping variable and any of the three scales.

Table 26 provides mean scores for each of the four identified groups on each of the three scales. Results indicated a higher mean for the Clinicians' Self Image Concerns scale for the 51 to 80 age group. Results indicated no mean difference on the Motivation Concerns scale. Lastly, results indicated a higher mean on the Client Privacy Concerns scale for the 20 to 50 age group. Small effect sizes were identified for each of the three scales, Clinicians' Self Image Concerns, Motivation Concerns, and Client Privacy Concerns scale, indicating negligible differences between group means.

Table 24

Frequency of each Response to the Question: Within which age bracket do you fall? (N = 185)

	20 to 30	31 to 40	41 to 50	51 to 60	61 to 70	71 to 80
N	1	24	65	43	36	16

Table 25

MANOVA Results Using the Three Scales as Dependent Variables and Age as the Grouping Variable

Pillai's Trace	F	*df*	Error *df*	p-value
.06	.87	12	540	.57

Table 26

Comparison of Mean Scores on each Scale between Age Levels (N = 185)

Scales	20 to 50 (*N* = 132)	51 to 80 (*N* = 53)	Cohen's *d*
	M (SD)	*M (SD)*	
Clinicians' Self-Image Concerns	2.00 (.82)	2.01 (.82)	0.01
Motivation	2.42 (.76)	2.42 (.71)	0.00
Client Privacy	2.90 (.63)	2.89 (.63)	0.02

Note. One participant did not respond.

Qualitative responses. The qualitative data indicates that participants were hesitant to video record for a variety of reasons. A total of 115 qualitative responses were provided. The qualitative question asked was: What additional factors, if any, contribute to your reluctance to video record your DBT individual therapy sessions? The following are 12 qualitative responses from participants who report no concerns.

- Nothing! I'm a complete show-off.
- None.
- None.
- None.
- None.
- None.
- I am not really reluctant, especially since many of my sessions were reviewed by Randy Wolbert during the Practice Improvement Project (PIP), who instilled confidence within me that I was doing what I need to be doing in my DBT sessions.
- Taping is good. It makes us better at what we do. Clients are "under the microscope" all the time; we, too should be willing to be exposed in this manner. Any reluctance I reflect is an attempt to be honest of the real discomfort of being taped and critiqued by peers.
- I felt reluctant to record my sessions until I attended the Foundational Training from Behavior Tech. After the training, I felt excited to record my sessions because I realized it is a non-threatening process where I can LEARN how to be a

better therapist by getting feedback from supportive team members and other DBT people about where I could improve with following the DBT protocol. I have become very interested in my video-taped sessions as a tool for learning, growing, and most importantly - helping my clients by doing DBT that is proven to work.

- I video recorded for Intensive Training about one session per month and consulted with BTech consultant. The video-taping was an invaluable experience and I learned so much. However, I have experienced that others on my team who have not had this opportunity are very reluctant and see it as a very adverse experience.
- I am generally not reluctant to tapes sessions. I think it is a great tool as long as I know and the client knows that confidentiality will be maintained--i.e., encrypted computer/data storage, clear method of destroying video after it has been used, and certainty that it is only viewed by authorized individuals.
- I am generally not reluctant to video therapy sessions for training and professional development if the client consents. On my current team, I requested that senior practitioners shared their tapes to the team prior to having junior clinician's tapes shown. This would have helped alleviate performance anxiety on my part and demonstrated an effective feedback session before being subjected to one.

The following is 1 qualitative response from a participant who did not know what additional concerns to add.

- I don't know

Fourteen responses were provided that related to concerns about technology.

- No video equipment available. Just went into private practice and cannot afford to purchase myself.
- Setting up adequate recording devices on a limited budget.
- The cost of the equipment, certification is costing quite a bit of money and as of yet I have not had any additional reimbursement.
- The equipment working properly. On two occasions - I "taped" the session - and it did not work.
- Lack of technical experience and lack of appropriate equipment to use to video record.
- Technical problems, operating electronics, poor sound quality.
- The equipment is a hassle.
- Logistics, ease of obtaining equipment.
- Technology problems.
- Having the equipment on site and setting it up.
- Hassle of setting up equipment.
- Accessibility to recording devices.
- We haven't had the technology at our rural community mental health center. Now that our IT staff is going to show us how to use our camera on our laptops, it will be actually possible and not terribly clumsy. I'd like our team to start doing taping, and I'd like to start, too, we just haven't been able to get through all the barriers before.
- Lack of video equipment. I have done audio recording many times.

Twenty-four responses indicated concerns related to client privacy and the belief video observation inhibits or alters therapy sessions.

- Client modifying behavior due to the recording.
- It changes the dynamic of the session.
- I think video recording has an effect on both client and provider. Demand characteristics would likely interfere with the session being authentic and a true representation on the clinical experience.
- The act of observation by itself changes behavior. When one is known to be observed, one can alter one's behavior to meet the expectations of the observer. For video-taping to be optimally effective it would need to be a routine part of each session with the therapist and client having no idea which tapes are to be reviewed. Even then, the reality of observation changes the therapeutic interaction in sometimes very important ways. Clients will be reluctant to share highly sensitive information which can have severe consequences for their therapy. I am hesitant to regularly tape sessions for this reason. We engage in therapy to meet the needs of the client. To tape for this purpose is to place a burden on our clients that is not about what they are in therapy for. Taping for training purposes is a necessary process, taping to test adherence is not, the same goal could be met through taping a staged session. Yes, it will be staged but I would argue in many cases the taped real sessions will be staged in a way as well.

- My primary reluctance is the change it creates in individual therapy for the client; my experience is that the session loses significant value when any recording device is present.
- As indicated above, client concerns about privacy are my biggest concern.
- Clients' reluctance to having the sessions video recorded has contributed to my reluctance.
- Many of my clients do not want to be video recorded and I do not want to push the issue with them.
- I wouldn't want to do it with a client who is against it or even passively against it.
- I am not reluctant at all unless the client is reluctant.
- Client's decline even audio taping. I'm willing to audio or video.
- I am not reluctant to video tape; however, any reluctance I have is related to client not wanting to be video-taped and is highly opposed to having sessions taped.
- Client comfort - many report that this would make them uncomfortable and I am concerned it may become a therapy interfering factor.
- The possibility of clients requesting to view or have a copy of the sessions.
- Concerns related to releases required for this form of sharing information. Concerns if legal proceedings occur if video could be subpoenaed.
- My ability to keep client's confidentiality.
- If video-taping impacts the quality of therapy for my client. I have my client's interest in mind and don't want them to feel uncomfortable.

- I do not have an issue with video recording as I appreciate the feedback. However, if I had a client who was concerned about their confidentiality I would discuss this at the DBT consultation group and take this on a case by case basis.
- Clients have reported it being a big distraction to the therapy session that they are paying for feeling a need to perform or end up self-sabotaging and feeling shame.
- In my experience, informing clients of video recording sessions can cause them to feel unsettled about their privacy and what is being done with the recording behind closed doors. Some clients have expressed paranoia that the information recorded could be held against them or that people may be laughing at their problems. The concern typically reduces after a relationship is built but it can detour clients that are not fully committed to treatment.
- It seems clients are more reluctant to be videotaped if they have to be on camera. If we could only do voice recording and not have the client's face on the video tape I think we would have higher compliance.
- Axis II clients can be quite sensitive to changes in therapy environment. If client is uncomfortable, I may get distorted information from them.
- My biggest concern is that the client will not feel comfortable and the session will be unauthentic.
- We choose one to three client's to record a year and when the client makes a request to not record a session I honor that. I find client's that agree to recording are very willing to outside of when they are being affected by personal concerns. Typically, at these times they are experiencing intense sadness, loss or shame.

Two clients mentioned at the end of the session they would have been self-conscious and not have been able to disclose like they did if the camera was on. One time I chose not to record as I was sick and it landed up being a good session for the client. In the future I likely will record.

One response indicated concerns about agency protocol:

- It's not part of standard protocol at my agency. It rarely happens as part of the team.

Twenty nine responses reflected concerns about therapist motivation.

- My own issues regarding my body image. It is difficult to see myself on camera and that makes me somewhat reluctant to video record. Additionally, perfectionism can get in the way.
- Performance anxiety.
- Honestly, it just feels a bit awkward to see oneself on a screen. Perhaps I'm experiencing some emotional vulnerability, so I apply my DBT skills to reduce my vulnerability and I video tape anyway.
- Insecurity about my lack of experience and training and having others' view my tapes. I value feedback and know it would greatly inform me to work more effectively with clients. I would be less reluctant if I'm visually able to see others' examples of adherent and non-adherent therapy sessions prior to video-taping my own.
- Self-conscious and don't like being video-taped for anything. The idea of watching myself is much more uncomfortable than knowing others will watch it.

- I feel more uncomfortable in any setting when being video recorded so it may impact my effectiveness.
- I think the biggest hesitation comes from not having done it before. Once I do it, I believe it will get easier. What holds me back from doing it is that is just isn't something our team is doing...we talk about needing to do it but it just hasn't happened. Likely for all the reasons you list in your survey!
- Insecurity
- Don’t like watching myself
- When I know I am being videoed, I am concerned that I am more worried about doing my therapy according to DBT protocol rather than being totally attentive to the client's therapeutic needs.
- I just started providing DBT individual and group therapy and only have a handful of clients in the beginning stages of individual therapy.
- Feel like so many things to not forget/to cover adherently
- Conflict with members of consultation team.
- Team support of the use of video recording.
- I have never seen anyone actually performing DBT therapy through a video recording besides the main people who developed the program. I do not feel skilled in conducting DBT sessions at this time and only see one person on an individual basis for DBT therapy at this time.
- I get anxious about my peers watching me.

- My own anxiety about interpreting feedback as an indication I'm not doing well - and I understand that's not totally true.
- Fear of judgment or client disapproval.
- I believe there is a shame trigger for me, where my doubts of my abilities keep me from being fully confident in what I do; there is a fear that I'm going to be told I am doing it "wrong."
- At this point, for the number of times (4x/year for 2-3 years) I have video recorded, I have not received feedback as to how I'm doing directly related to the videos. This contributes to my reluctance to keep doing it.
- Judgments of the team when they view the video.
- Being told I am not doing it right and fearing my agency will have billing issues as a result and discipline me.
- Receiving feedback/criticism
- Wanting to know that I am following the model, however if I'm not it is hard to be vulnerable with a group of therapists who I have respect for. I think we all want to do right by clients and this is a good way to check to make sure we are, and it makes us vulnerable.
- Helpful feedback from the people viewing the recording.
- Please note I have done audio recordings of my Individual DBT sessions. The determining factor regarding reluctancy is whether or not the reviewer is fair, validating, and overall encouraging in their critique.

- Expressions from other team members about how they find reviewing taped sessions not useful.
- It is hard to make yourself vulnerable to others, and with that said, the exposure of doing so opens you up to valuable learning opportunities and gets easier over time
- a) Performance anxiety, b) Other consultation team members have not videotaped, c) I don't think our team has much skill/training in rating adherence, and d) Our team is pretty content with the status quo.

Three qualitative responses reflected concerns about time.

- I forget to prepare ahead of time and get the video equipment from the office manager's office.
- Getting access to equipment was a problem before I got Vidyo on my laptop. Dealing with the technical aspects of setting up the recording takes some time and attention I would rather spend with the client.
- It takes time to set up video equipment and change tapes when recording is full, which is my only current barrier to taping all sessions. I do find taping sessions to review during supervision very helpful.

Twenty nine responses reflected multiple concerns, such as time, client privacy, and therapist motivation.

- Technical issues, time-consuming, may be a distraction from the therapy being provided, and not everyone is doing it.
- I don't know if we are set up to video record and I don't have much interest in technology.

- Remembering to record sessions, setting up the physical environment to record effectively, and not having time to review sessions in supervision or in consultation team meetings are all barriers for me, personally.
- I'm open to it and think it is a great idea. The only problem that comes to mind is how to find the time to review team members recording along with other issues related to time and meeting my organizations productivity requirements and obtaining productivity hours for DBT related video recording needs.
- Primary concern is the issue of therapy and the need to focus on the client's treatment needs and not my own needs.
- Time, technology, overwhelmed with other tasks--takes extra effort. I desire to record them, but haven't prioritized the necessary steps to change my behavior.
- My biggest hesitation is bringing it up to my client and managing their resistance and needing to spend therapy time to prepare them to video-taped. Then there is the technology piece that never goes well. The recording did not work or was not loud enough and then having to ask the client again to record a session.
- Client feeling unwilling to do it, feeling that another professional would judge me harshly and without non-judgmental intent, I hate having to see my aging self on the screen--what a downer.
- Inadequate or nonexistent equipment in our agency and concerns that it might inhibit client’s participation.
- The overall interference with therapy sessions and client's concern regarding confidentiality.

- Old age, lack of participation in video recordings.
- Technical challenges as a sole provider, concerns about feedback, lack of motivation as being considered a provider by state of MN has not yielded ANY benefits. Frustrated by hoops required by state with no increase in pay for DBT.
- Our team is continuing to meet DHS requirements and DBT adherence standards-- sometimes other administrative issues (transitioning to electronic forms throughout the clinic, maintaining consult consistency and adherence, and other challenges). It is difficult to fit it all in and know how to prioritize effectively while making client care primary. It's a work in progress. :)
- We have a team of 12 providers plus three interns. Each week we review as a team one video-taped session by one of our providers. Everyone presents a taped session before we begin the next 'round' of taping sessions. We have one video-recorder for the clinic.
- The hassle of finding/getting a camera and setting it up in my office. The change in dynamics of therapy with the client who is concerned about being on camera.
- I don't have a video camera and don't know if my agency has one, and if they do, I don't know if I know how to use it. I also don't know what paperwork I would have to have the client sign to use the video recorder, and it would take me time I don't feel that I have to figure out what how to use the recorder and how to ensure that the client has signed the appropriate paperwork to make it ok. And I don't know how the client would feel about it, and how to use it without lowering trust

with the clients, who typically have very poor trust. Also, I don't have any extra funds to purchase video equipment at this time.

- Recording materials- agency either doesn't have them, or gaining access takes an act of Congress to get them. Secondly, it's just a matter of comfort and practice. I know if I did it more, it would reduce the reluctance I currently have. I am confident I could address client issues with my clients re: privacy, etc.
- Need Additional Training, Limited Technology.
- Primarily, I worry that my clients will be inhibited and therapy may not be as effective.
- The impact that having video recording equipment may have on my clients' therapy experience. Some, while voicing their permission to tape, have stated that they altered their behavior due to the process. Their well-being comes first, and taping is a distant second.
- Not having the equipment to record or play sessions, client's not feeling comfortable recording.
- Knowledge of how to work technology and keep HIPPA compliant.
- Personal cost, potential resentment at increasing requirements/demands of DBT/limits.
- The actual set up of the equipment. Time and client’s reluctance.
- Finding time for review of tapes; concerns about client reluctance; cumbersome process at this agency.
- Lack of time; Burnout.

- Client’s concerns about privacy and individual insecurities about feedback
- My main concern with video recording is the client's ability to experience privacy and being comfortable with being recorded. I would not want the videotaping to interfere with individual sessions. It has been my experience that reviewing video tapes is extremely valuable to professional development. Sometimes videotaping is a challenge due to accessibility to the equipment.
- The time it takes to schedule the video equipment, set up the equipment. Extra step with client in getting their agreement and it does impact session at times.
- I do not like setting it up and it all takes extra time to send the video to where it needs to go. Our agency has high expectations of seeing as many clients as possible.

Two responses were not relevant to individual DBT therapy.

- These responses refer to taping DBT skills group. I do not do individual DBT therapy.
- I wish there had been an N/A option. I do not have a non-DBT supervisor. We actually do not have video recording capabilities in our agency, so the answers I have given pertain to the use of a digital recorder. The agency does not have enough of them, so they are stored in a secure area. By the time I think "Oh, I should record this," the session is already in progress. I and a couple other coworkers had been really good about recording earlier on, but there were other team member(s) who did it only once or not at all. I can imagine the inconvenience of obtaining and setting up video equipment, specifically

considering the set-up of my office, so I think that would also be a hindrance. I certainly see the benefits of recording sessions, and I am thankful to have had the opportunity to do so. The feedback I have received from my team has been invaluable.

Primarily, responses indicated reluctance to video record due to: unfamiliarity with technology, concerns about client privacy, Motivation behaviors, lack of agency support, fearing judgment from colleagues/supervisors, and concern about performance expectations. These findings support demographic responses indicating the majority of respondents indicated recording sessions less than 20% of the time.

In summary, this chapter reviewed statistical findings from EFA, MANOVA, and post hoc tests. In addition, qualitative data was presented to provide supporting evidence. In summary, the statistical data, in conjunction with qualitative responses, indicates reluctance to video record due to: concerns about client privacy, motivation, and treatment targets. Factors that indicate low reluctance to video record revolve around: receiving positive feedback about adherence to DBT protocol, knowledge that other clinicians are video recording their DBT sessions, and additional training in DBT.

Chapter 5: Discussion

This study sought to examine what factors, if any, resulted in reluctance to video record individual DBT sessions. Reluctance was examined using a 29 question survey consisting of: a 21-item Likert scale, 7 clinician characteristics, and 1 open-ended qualitative question. This chapter discusses the major findings of the EFA, Clinician Characteristics, and Qualitative Responses. The following section will also highlight consistencies between current literature and results of this study. Though research was dated and limited, anecdotal information provided by respondents strongly reflected existing literature. Lastly, study limitations, training, and research recommendations will also be discussed. In addition, future research, recommendations, and limitations are addressed.

EFA Results

The purpose of this study was to investigate the reluctance of DBT providers to video record individual DBT sessions, through the creation of a reluctance scale. EFA results provided evidence for the presence of three factors: Clinicians' Self-Image Concerns, Motivation Concerns, and Client Privacy Concerns. In total, the three factors cumulatively accounted for 40.40% of the variance. A holistic picture may not have been obtained given only 40.40% of the variance was explained based on the three factors. This indicates other underlying constructs may additionally explain the reluctance to video record DBT sessions.

Sixteen out of 21 scale questions statistically, and theoretically, loaded onto one of the three factors with a coefficient of .40 or higher. Reluctance to video record

individual DBT therapy sessions was highest for the scale, Client Privacy Concerns (*M = 3.1*). Reluctance to video individual DBT therapy sessions was lowest for the scale, Clinicians' Self-Image Concerns (*M = 2.0*).

Factor one. This factor, Clinicians' Self-Image Concerns, was defined as: Concern that despite the clinician's belief she is competent in providing DBT, she might be deemed incompetent by a supervisor and she has also witnessed others conduct non-adherent DBT.

Clinicians who have concern of being exposed as non-adherent to a particular theoretical orientation, such as DBT, may be hesitant to videotape. Such fears could fuel the perception that video observation is a liability rather than an educational tool (Goldberg, 1983; Haggerty & Hilsenroth, 2011). A recommendation for providers who may be wary of video recording their sessions given potential legal drawbacks is to state, in both verbal and written formats, prior to treatment that videos are "recorded solely for quality improvement purposes, thus they are likely not discoverable by plaintiff's attorneys" (Makary, 2013, p. 1592). For clinicians wary of inter-agency politics and/or not feeling fully supported by their consultation team, external consultation is recommended. DBT offers national consultation to clinicians and given the transferability of video files, external review becomes a promising, viable source of peer feedback and, simultaneously, provides distance from inter-agency politics that could potentially skew feedback (Makary, 2013). However, it should be noted that external consultation does not replace the necessity to repair relationships within DBT teams and between providers, if tenuous professional relationships are the cause for outsourcing

video recorded sessions. In addition, providing additional training - including watching others conduct adherent DBT and about DBT treatment hierarchies - is recommended.

Factor two. This factor, Motivation Concerns, was defined as: The therapists are not motivated and DBT teams are not exhibiting behavior indicating team members are motivated either.

Therapists feel that they are not conducting DBT competently and are experiencing burn out. This factor highlights the importance of team consultation and treating the therapist. The primary function of team consultation is to increase the therapist's motivation to provide DBT services and to facilitate adherence (Rizvi et al., 2013). The primary function of individual therapy is to increase the client's motivation to change (Linehan, 1993a). If the therapist is struggling with motivation to conduct DBT, this could affect service delivery. According to SAMHSA (2012), team consultation serves to support, provide consultation to, and reorient clinicians to operate within the DBT model. Also, in team consultation, it is recommended expectations be reviewed, in both written and verbal formats, regarding the use of video recording. In addition, a statewide training on treating the therapist, which is a vital component of team consultation, is recommended to ensure therapists are maximizing what team consultation has to offer.

Factor three. The third factor, Client Privacy Concerns, is defined as: The clinician is concerned about the client's privacy and feels the client would be inhibited in therapy. Additionally, the client has expressed concerns about privacy.

To offset concerns about patient privacy, it is strongly recommended that therapists establish consent from the onset of services versus introducing the idea of video observation mid-therapy. Clients should be informed if video recordings will be used for self-review, supervision, or in team consultation and, consequently, how their privacy will be protected. Clients should be informed that the focus of video recording is to shape clinician behavior to ensure the highest quality of treatment. During the course of treatment, if a client withdraws consent for recording at any time, services should not be withheld. Therapists could introduce video recording through discussions, practice sessions, or allowing clients to view mock recordings.

Clinician characteristics. Reluctance was also evident based on responses to clinician characteristics. Results indicated, currently, over 90% of respondents indicated video recording sessions less than 20% of the time even though more than 50% endorsed previous experience video recording DBT sessions.

Two of seven clinician characteristics were statistically significantly related to at least one of the three scales. One characteristic, assessing frequency of video recording, resulted in a statistically significant higher mean on the Clinicians' Self Image Concerns scale for the 0 to 19% group. The higher mean indicates more concern about Clinicians' Self-Image. Also, a strong effect size was detected for the Client Privacy Concerns scale (d = -0.82), indicating a strong difference between group means. This indicates additional exposure to video recording may reduce concerns about Clinicians' Self-Image Concerns.

The second characteristic, assessing whether clinicians have previously recorded DBT sessions, resulted in a statistically significant higher mean on the Clinicians' Self Image Concerns scale for participants who had not previously recorded DBT sessions. In addition, a higher mean was indicated for the Client Privacy Concerns scale for participants who had not previously video recorded DBT sessions. This indicates previous exposure to video recording may result in reduced concerns about Clinicians' Self-Image and Client Privacy.

Qualitative Responses Results

The qualitative responses support the statistically significant findings regarding the two clinician characteristics described above. In particular, the respondents who indicated no reluctance to video record described previous, positive exposure to video recording. Also, qualitative responses indicated the presence of other potential factors that could contribute to the reluctance to video record sessions such as time and technology, which were variables that were not assessed in this study. Overall, participants reported seeing the benefit of video recording and how it improved their fidelity to the model when: receiving positive feedback, using external reviewers, receiving agency support, receiving positive reinforcement, and having the opportunity to consult with other DBT clinicians.

Video recording recommendations. Based on this study, this writer also recommends that each certified DBT team leader present video recordings of their individual DBT sessions, on a quarterly basis, for review in DBT consultation using an appropriate checklist, such as *A Guide to Viewing a DBT Session*. A quarterly basis is

recommended because treatment plans for clients must be updated every 90 days (3 months) according to the Minnesota Health Care Programs Manual; with this sequence, a link is established between treatment planning and review of cases. Also, team leaders would be able to use recordings to assist new and/or therapists struggling with the DBT protocol.

Contribution

The minimal use of video recording in the counseling field represents a gap in the social sciences field. For instance, in the medical field, the use of video recording is commonplace. These results are useful for DBT and in the field of counseling for several reasons. The reluctance to video record – on both the part of client and clinician – may represent a systemic issue to reduce stigma surrounding mental illness. However, video observation is useful with high-risk clients, such as those who receive DBT, and those who may be at risk for hospitalization because of the mentally taxing, complex, and severe nature of client problems; video observation can be used to identify overarching themes. Also certified DBT providers are reimbursed at a higher rate than traditional psychotherapy services; therefore; video recording of sessions is a crucial first step in enforcing state level policy requirements and reducing medical efficiencies due to non-compliance.

Future Research

Future research includes re-sampling individual DBT providers in the state of Minnesota now that three factors have been identified and conducting a confirmatory factor analysis (CFA) to ensure the scale is valid. In addition, a larger sample size would

allow half the data to be analyzed via EFA and half the data to be analyzed via CFA. However, sample size is not the only factor to consider; for example, strong regression coefficients, indicating quality items, can mitigate a small sample size.

Assessing the role of additional clinician characteristics, such as provider status – mental health professionals versus mental health practitioners – is recommended for future research. Another clinician characteristic to assess in future research is whether the DBT provider is also a clinical supervisor. This is important as the effective use of video observation largely depends on the supervisor's competency to use it as a learning tool in supervision.

Limitations

The methods of EFA involve many subjective aspects – given the process of extracting factors, choosing appropriate rotation, and labeling factors. At this time, other scales measuring this construct do not exist, resulting in the inability to assess for concurrent validity. A larger sample size would have offered the opportunity to test half the data set through EFA and half the data set through CFA to ensure a solid model has been created. Moderate effect sizes resulted in non-statistically significant effect sizes, which could be due to an unequal distribution of the sample among various clinician characteristics. Unequal distribution of the sample may have also resulted in low power due, which could also result in undetectable effect sizes.

Clinician characteristics were variables that were not subject to manipulation, as participants self-selected into respective categories. Consequently, participants may have under- or over-estimated certain characteristics; for example, the majority of participants

rated themselves as knowledgeable about DBT protocol. Respondents may have been hesitant to indicate low or no knowledge of DBT protocol. Non respondents may have been different in ways that are unknown but significant compared to respondents.

Lastly, qualitative responses were not statistically analyzed. One qualitative response was based on DBT skills group - stating, "These responses refer to taping DBT skills group. I do not do individual therapy." Results are limited to DBT individual therapy providers in the state of Minnesota.

Conclusion

In summary, the research indicates several factors contribute to therapist reluctance to video record therapy sessions. Primary concerns reflect Clinicians' Self-Image, Motivation, and Client Privacy. Behavioral principles such as shaping clinician behavior through the use of positive feedback, knowledge other therapists are video recording sessions along with additional training appear to decrease concerns. At this time, it appears some providers can attest to the invaluable insight offered through video recording; however, it is important to ensure client privacy and safety is protected. The most effective use of video observation occurs when all parties are in agreement about the purpose, length, and nature of how video will be used. As with the qualitative research cited, though the qualitative responses for this study possessed certain limitations, a certain depth and richness was extracted that was not evident through the use of quantitative research.

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Appendix A: A Guide to Viewing a DBT Session

A Guide to Viewing a DBT Session

When reviewing DBT sessions (either group or individual) ask the following questions:

1. What strategies were used?
   A condensed version of the strategies listed in the tables of the treatment manual (Linehan, M.M. (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder*) is listed below for your reference. Please note that this list is NOT A SUBSTITUTE FOR KNOWING THE MANUAL.
2. What is going on in your mind as you watch the session?
3. Can you find any errors?
4. What else can be done?
5. Can you anticipate what the therapist will do next?
6. What would you do next?

DBT Treatment Strategies

Table 7.1 Dialectical Strategies (p. 206)
- ❑ Balances treatment strategies within session
- ❑ Models dialectical thinking and behaviors
- ❑ Highlights paradoxical contradictions
- ❑ Speaks in metaphors, tells parables and stories
- ❑ Plays the devil's advocate
- ❑ Extends
- ❑ Activates "wise mind."
- ❑ Makes lemonade out of lemons
- ❑ Allows natural change
- ❑ Dialectical assessment

Table 8.1 Emotional Validation Strategies (p. 229)
- ❑ Provides opportunities for emotional expression; empathizes and accepts feelings
- ❑ Helps observe and label feelings
- ❑ Reads emotions
- ❑ Communicates that feelings are valid

Table 8.2 Behavioral Validation Strategies (p. 236)
- ❑ Helps patient observe and describe own behavior
- ❑ Helps identify the "should"
- ❑ Counters the "should"
- ❑ Accepts behavior
- ❑ Validates disappointment in behavior

Table 8.3 Cognitive Validating Strategies (p. 241)
- ❑ Helps patient observe and describe own thought processes
- ❑ Helps assess the facts and differentiate events from interpretations of events
- ❑ Searches for the "kernel of truth"
- ❑ Acknowledges "wise mind"
- ❑ Respects differing values

Table 8.4 Cheerleading Strategies (p. 245)
- ❑ Communicates a belief that patient is doing best
- ❑ Encourages and actively expresses hope
- ❑ Focuses on capabilities
- ❑ Modulates external criticism
- ❑ Praises and reassures
- ❑ Is realistic in expectations and deals directly with patients fear of therapist's insincerity
- ❑ Stays near in a crisis

Table 9.1 Behavioral Analysis Strategies (p. 256)
- ❑ Helps define the problem behavior
- ❑ Conducts a chain analysis
- ❑ Generates hypotheses about variables influencing or controlling behaviors in question

Table 9.2 Insight Strategies (p. 267)
- ❑ Focuses insights on DBT target behaviors and their precursors
- ❑ Explores current, observable, public behaviors and events
- ❑ Uses DBT assumptions about patients and biosocial theory
- ❑ Favors nonpejorative, empathetic interpretations
- ❑ Interprets behavior in terms of current eliciting and maintaining variables.
- ❑ Observes effects of insights, and changes patterns or type of insights offered accordingly
- ❑ Uses insights sparingly and surrounds them with validation
- ❑ Highlights or comments on behavior
- ❑ Helps observe and describe recurrent patterns
- ❑ Comments on possible implications of behavior
- ❑ Explores difficulties in accepting/rejecting hypotheses about behavior in an open, flexible manner

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Table 9.3 didactic strategies (p. 273)
- ❑ Provides information about the development, maintenance, and change of behavior in general
- ❑ Presents suicidal/NSSI and impulsive behaviors as problem-solving behavior
- ❑ Provides readings on behavior, treatments, bpd
- ❑ Presents information about behavior and bpd to family

Table 9.4 solution analysis strategies (p. 276)
- ❑ Helps identify wants, needs, and goals
- ❑ Helps generate solutions
- ❑ Helps evaluate solutions generated
- ❑ Helps choose a solution
- ❑ Troubleshoots

Table 9.5 orienting strategies (p. 283)
- ❑ Orients to DBT and patient's role in therapy
- ❑ Rehearses exact response to problem

Table 9.6 commitment strategies (p. 287)
- ❑ Highlights and discusses pros and cons
- ❑ Uses devil's advocate
- ❑ Uses "foot-in-the-door" and "door-in-the-face"
- ❑ Highlights prior commitments
- ❑ Presents freedom to choose while presenting realistic consequences of choices
- ❑ Uses principles of shaping in eliciting commitment
- ❑ Generates hope by cheerleading
- ❑ Therapist and patient agree specifically on homework

Table 10.2 contingency management procedures (p. 298)
- ❑ Orients to contingency management
- ❑ Reinforces target-relevant adaptive behaviors
- ❑ Extinguishes target-relevant maladaptive behaviors
- ❑ Uses aversive contingencies when necessary
- ❑ Determines potency of consequences
- ❑ Uses natural consequences over arbitrary reinforcers whenever possible
- ❑ Uses principles of shaping in reinforcing behavior

Table 10.3 observing-limits procedures (p.323)
- ❑ Monitors own limits in conducting therapy
- ❑ Communicates own limits honestly and directly
- ❑ Extends limits temporarily when necessary
- ❑ Consistently firm about own limits
- ❑ Combines soothing validation and problem solving with observing limits

Table 11.1 skill acquisition procedures (p. 333)
- ❑ Assesses target-relevant abilities
- ❑ Instructs in skills to be learned
- ❑ Models skilled behavior

Table 11.2 skill strengthening procedures (p. 335)
- ❑ Uses behavioral rehearsal
- ❑ Reinforces skilled behavior
- ❑ Gives behaviorally specific feedback
- ❑ Coaches

Table 11.3 skill generalization procedures (p. 338)
- ❑ Programs generalization of skills
- ❑ Consults between sessions to help apply skills in vivo
- ❑ Gives audiotape of session to listen to between sessions
- ❑ Gives in vivo behavioral rehearsal assignments
- ❑ Helps create environment that reinforces skilled behaviors

Table 11.4 exposure-based procedures (p. 348)
- ❑ Orients to exposure-based procedures and elicits commitment to collaborate
- ❑ Provides nonreinforced exposure to cues that elicit problematic emotions
- ❑ Blocks action tendencies to problem emotions
- ❑ Helps patient express converse emotions to those she is feeling
- ❑ Enhances patient's sense of control over aversive affect-arousing events
- ❑ Makes use of more formal exposure-based procedures as necessary

Table 11.6 cognitive restructuring procedures (p. 365)
- ❑ Helps patient observe and describe her own thinking style, rules, and verbal descriptions
- ❑ Identifies, confront and challenges dysfunctional rules, labels, and styles in a dialectical manner
- ❑ Helps generate more functional and/or accurate thinking styles, rules, and verbal descriptions
- ❑ Helps to develops guidelines on when to trust and when to suspect patient's own interpretations

Table 12.2 irreverent communications strategies (p. 394)
- ❑ Matter-of-fact voice tone with respect to maladaptive behaviors
- ❑ Uses logic irreverently to weave a web
- ❑ Employs a deadpan or highly intense style, as appropriate, to contrast patient's style
- ❑ Uses dialectical strategies in an irreverent manner
- ❑ Plunges into sensitive areas
- ❑ Uses direct confrontation of dysfunctional behavior
- ❑ Calls bluff
- ❑ Oscillates intensity of emotions, voice, posture;silence
- ❑ Assumes omnipotence or admits impotence as appropriate

Appendix B: Minnesota Rule 9505.0370 subpart 12

Subp. 12. Dialectical behavior therapy.
"Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Appendix C: Minnesota Rule 9505.0372 subpart 10

Subp. 10. Dialectical behavior therapy (DBT).
Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l;.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must: (1) be 18 years of age or older; (2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services; (3) meet one of the following criteria: (a) have a diagnosis of borderline personality disorder; or (b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas; (4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and (5) be at significant risk of one or more of the following if DBT is not provided: (a) mental health crisis; (b) requiring a more restrictive setting such as hospitalization; (c) decompensation; or (d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:
(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must: (a) identify, prioritize, and sequence behavioral targets; (b) treat behavioral targets; (c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session; (d) measure the client's progress toward DBT targets; (e) help the client manage crisis and life-threatening behaviors; and (f) help the client learn and apply effective behaviors when working with other treatment providers. (2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part9505.0371, subpart 5, item D. (3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other

dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas: (a) mindfulness; (b) interpersonal effectiveness; (c) emotional regulation; and (d) distress tolerance. (4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional co-facilitating with a mental health practitioner. (5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to
part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must: (1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart; (2) be enrolled as a MHCP provider;(3) collect and report client outcomes as specified by the commissioner; and (4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated: 1) A DBT team leader must: (a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner; (b) have appropriate competencies and working knowledge of the DBT principles and practices; and (c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices. (2) DBT team members who provide individual DBT or group skills training must: (a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner; (b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program; (c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program; (d) participate in DBT consultation team meetings; and (e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Appendix D: Minnesota Rule 9505.0371 subpart 5

Subp. 5. Qualified providers.

Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways: (1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E; (2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness; (3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification; (4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350; (5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301; (6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or (7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections148.171 to 148.285, and meets one of the following criteria: (a) is certified as a clinical nurse specialist; (b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or (c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways: (1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and (a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or (b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met; (2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients; (3)

is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training; (4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or (5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when: (1) the mental health practitioner is: (a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or (b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and (2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of: (a) direct practice; (b) treatment team collaboration; (c) continued professional learning; and (d) job management.

D. A clinical supervisor must: (1) be a mental health professional licensed as specified in item A; (2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice; (3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement; (4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised; (5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years; (6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following: (a) capacity to provide services that incorporate best practice; (b) ability to recognize and evaluate competencies in supervisees; (c) ability to review assessments and treatment plans for accuracy and appropriateness; (d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and (e) ability to coach, teach, and practice skills with supervisees; (7) accept full professional liability for a supervisee's direction of a client's mental health services; (8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients; (9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee; (10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan; (11) apply evidence-based practices and research-informed models to treat clients; (12) be employed by or under contract with the same agency as the supervisee; (13) develop a clinical supervision plan for each supervisee; (14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices; (15) establish an evaluation process that identifies

the performance and competence of each supervisee; and (16) document clinical supervision of each supervisee and securely maintain the documentation record.

Appendix E: Email Invitation

Dear DBT IOP Provider:

My name is Sonal Markanda and I am a doctoral candidate in counseling psychology at the University of Minnesota. For my dissertation, I am conducting a study entitled: "Creation and validation of a scale to measure the reluctance to video record individual Dialectical Behavior Therapy (DBT) sessions." The purpose of this study is to normalize and understand therapist reluctance to video record individual DBT therarpy sessions, develop policy that will increase the frequency of video reocrding and ultimately, improve clinical practice and client service delivery. You have been selected as a possible participant because you are enrolled as a MHCP eligible DBT IOP provider with the state of Minnesota. As part of this study, you will be asked to:

1) Electronically sign a consent form.
2) Complete the online reluctance scale, which includes the collection of de-identified demographic data.

If you are interested, please respond to mark0293@umn.edu and you will receive the informed consent form and survey.

The Primary Investigator (PI) of this study is Sonal Markanda, MSEd, LPC, NCC, who can be reached at mark0293@umn.edu. This study is being conducted under the supervision of Dr. Kay Herting Wahl, EdD, who can be reached at kwahl@umn.edu. If you have any questions or concerns regarding the study and would like to talk to someone other than the researcher(s), contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; telephone (612) 625-1650.

Appendix F: Informed Consent Form

Consent Form
Creation and validation of a scale to measure the reluctance to video record individual Dialectical Behavior Therapy (DBT) sessions

You are invited to participate in a qualitative research study assessing Dialectical Behavior Therapy Intensive Outpatient Program (DBT IOP) providers' reluctance to video record individual DBT therapy sessions. Additional de-identified data including education level and professional status will be collected.

You were selected as a possible participant due to your status as a certified DBT provider in the state of Minnesota. Certified DBT providers in Minnesota must meet the requirements for an adherent DBT Intensive Outpatient Program (IOP) as defined by Minnesota Rule 9505.0370 subpart 12 and 9505.0372 subpart 10. Supervision requirements are defined in Minnesota Rule 9505.0371 subpart 4. I ask that you read this form and ask any questions you may have before agreeing to participate in the study.

This study is being conducted by: Sonal Markanda, MSEd, LPC, NCC - Doctoral student at the University of Minnesota (UMN) - Twin Cities - College of Education and Human Development (CEHD); Mental Health Program Consultant with the Adult Mental Health Division (AMHD) at the Minnesota Department of Health and Human Services. UMN doctoral advisor: Dr. Kay Herting Wahl.

Background Information:
The purpose of this study is to answer the following research questions: 1) How reluctant are DBT Intensive Outpatient Programs (IOP) providers to video record individual DBT therapy sessions?

Given Dialectical Behavior Therapy (DBT) is a behavioral oriented therapy, with observable and measurable interventions, information on video observation in DBT is critical. In addition, given video observation can reorient therapists to remain adherent to the DBT model (which has been shown to reduce client symptom severity and therapist burnout) the value of video recording cannot be underestimated; however, there is little research and outcome data regarding video recording in the field of psychology. The information from this study will enhance the knowledge available about video observation.

Procedures:
If you agree to participate in this study, I ask you to do the following:

1) Sign this consent form electronically.
2) Use the link provided in this email to complete the online reluctance scale.

Risks and Benefits of being in the Study:
This study has minimal risk: You may experience mild distress responding to questions about your observation experience. Second, you may experience mild distress responding to questions about environmental factors that may influence your work performance (i.e., agency support, etc.).

There are no immediate or expected benefits for you to participate in this research beyond having an opportunity to discuss and reflect on your use of video observation as it relates to DBT.

Compensation:
No compensation will be provided to participants in an effort to avoid any actual or perceived conflict of interest given the PI's role with the Minnesota Department of Human Services as a Mental Health Program Consultant in the Adult Mental Health Division.

Confidentiality:
The records of this study will be kept private. In any sort of report that might be published, no information will make it possible to identify participants. Research records will be stored securely and only researchers will have access to the records. Study data will be encrypted according to current University and State policies for protection of confidentiality.

Voluntary Nature of the Study:
Participation in this study is voluntary. Your decision to participate will not affect your current or future relations with the Minnesota Department of Human Services or the University of Minnesota. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:
The researcher conducting this study is: Sonal Markanda. If you have questions, **you are encouraged** to contact her at: mark0293@umn.edu. This study is being advised by Dr. Kay Herting Wahl, who can be reached at: kwahl@umn.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:
I have read the above information. I have asked questions and have received answers. I consent to participate in the study. An electronic signature is considered true and valid.

Signature:_____ Date: _____

Signature of Investigator:_____ _____ Date: _____

Appendix G: Survey

For questions 1-21, consider the following: How reluctant are you to video record your individual DBT sessions, <u>as of now</u>, when:

1. **Your video will be shown in DBT team consultation.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

2. **Your video will be shown to your <u>non-DBT</u> supervisor.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

3. **Your video will be shown to your <u>DBT</u> supervisor.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

4. **Your video will be shown to a <u>DBT</u> team member.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

5. **Your video will be shown to a <u>non-DBT</u> team member.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

6. **Your client's <u>primary</u> concern is Life-Threatening Behaviors (including imminent suicide risk).**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

7. **Your client's <u>primary</u> concern is Serious Quality of Life Interfering Behavior.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

8. **Your client's <u>primary</u> concern is Therapy-Interfering Behavior.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

9. **You are engaging in Therapy-Interfering Behavior.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

10. **You are engaging in Team-Interfering Behavior.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

11. **You are experiencing burnout.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

12. **You observe video recordings of another provider conducting <u>non-adherent</u> individual DBT.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

13. **You observe video recordings of another provider conducting <u>adherent</u> individual DBT.**

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

14. You receive feedback <u>you are</u> providing individual DBT according to the model.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

15. You receive feedback <u>you are not</u> providing individual DBT according to the model.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

16. You know others on your team are also video recording their sessions.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

17. You do not know if others on your team are also video recording their sessions.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

18. You receive additional training, specifically, about individual DBT.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

19. You are concerned about your client's privacy.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

20. Your client has voiced concerns about his or her privacy.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

21. You feel your client would be inhibited during therapy.

Completely Non-Reluctant | Somewhat Non-Reluctant | Somewhat Reluctant | Completely Reluctant

22. How would you rate your current knowledge of individual DBT protocol?

Extremely Knowledgeable Knowledgeable Low Knowledge No Knowledge

23. With what frequency do you currently video record your individual DBT sessions?

0-19% 20-39% 40-59% 60-79% 80-100%

24. What is your highest educational degree?

Bachelor's Master's Doctoral

25. With which gender do you identify?

Male Female Transgender

26. How long have you been providing DBT services?

Less than one year 1-5 years 6-10 years 11-15 years 15 + years

27. Have you previously, at any time, video recorded your individual DBT sessions?

Yes No

28. Within which age bracket do you fall?

20 to 30 31 to 40 41 to 50 51 to 60 61 to 70 71 to 80

29. What additional factors, if any, contribute to your reluctance to video record your individual DBT sessions? (open-ended)

Appendix H: Minnesota Rule 9505.0371 subpart 4

Subp. 4. Clinical supervision.

A. Clinical supervision must be based on each supervisee's written supervision plan and must: (1) promote professional knowledge, skills, and values development; (2) model ethical standards of practice; (3) promote cultural competency by: (a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability; (b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery; (c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and (d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process; (4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and (5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19. (1) Individual supervision means one or more designated clinical supervisors and one supervisee. (2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include: (1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised; (2) the name, licensure, and qualifications of the supervisor; (3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner; (4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee; (5) procedures that the supervisee must use to respond to client emergencies; and (6) authorized scope of practices, including: (a) description of the supervisee's service responsibilities; (b) description of client population; and (c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include: (1) date and duration of supervision; (2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor; (4) subsequent actions that the supervisee must take; and (5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Appendix I

- Nothing! I'm a complete show-off.
- None.
- None.
- None.
- None.
- None.
- I am not really reluctant, especially since many of my sessions were reviewed by Randy Wolbert during the Practice Improvement Project (PIP), who instilled confidence within me that I was doing what I need to be doing in my DBT sessions.
- Taping is good. It makes us better at what we do. Clients are "under the microscope" all the time; we, too should be willing to be exposed in this manner. Any reluctance I reflect is an attempt to be honest of the real discomfort of being taped and critiqued by peers.
- I felt reluctant to record my sessions until I attended the Foundational Training from Behavior Tech. After the training, I felt excited to record my sessions because I realized it is a non-threatening process where I can LEARN how to be a better therapist by getting feedback from supportive team members and other DBT people about where I could improve with following the DBT protocol. I have become very interested in my video-taped sessions as a tool for learning,

growing, and most importantly - helping my clients by doing DBT that is proven to work.

- I video recorded for Intensive Training about one session per month and consulted with BTech consultant. The video-taping was an invaluable experience and I learned so much. However, I have experienced that others on my team who have not had this opportunity are very reluctant and see it as a very adverse experience.
- I am generally not reluctant to tapes sessions. I think it is a great tool as long as I know and the client knows that confidentiality will be maintained--i.e., encrypted computer/data storage, clear method of destroying video after it has been used, and certainty that it is only viewed by authorized individuals.
- I am generally not reluctant to video therapy sessions for training and professional development if the client consents. On my current team, I requested that senior practitioners shared their tapes to the team prior to having junior clinician's tapes shown. This would have helped alleviate performance anxiety on my part and demonstrated an effective feedback session before being subjected to one.
- I don't know
- No video equipment available. Just went into private practice and cannot afford to purchase myself.
- Setting up adequate recording devices on a limited budget.
- The cost of the equipment, certification is costing quite a bit of money and as of yet I have not had any additional reimbursement.

- The equipment working properly. On two occasions - I "taped" the session - and it did not work.
- Lack of technical experience and lack of appropriate equipment to use to video record.
- Technical problems, operating electronics, poor sound quality.
- The equipment is a hassle.
- Logistics, ease of obtaining equipment.
- Technology problems.
- Having the equipment on site and setting it up.
- Hassle of setting up equipment.
- Accessibility to recording devices.
- We haven't had the technology at our rural community mental health center. Now that our IT staff is going to show us how to use our camera on our laptops, it will be actually possible and not terribly clumsy. I'd like our team to start doing taping, and I'd like to start, too, we just haven't been able to get through all the barriers before.
- Lack of video equipment. I have done audio recording many times.
- Client modifying behavior due to the recording.
- It changes the dynamic of the session.
- I think video recording has an effect on both client and provider. Demand characteristics would likely interfere with the session being authentic and a true representation on the clinical experience.

- The act of observation by itself changes behavior. When one is known to be observed, one can alter one's behavior to meet the expectations of the observer. For video-taping to be optimally effective it would need to be a routine part of each session with the therapist and client having no idea which tapes are to be reviewed. Even then, the reality of observation changes the therapeutic interaction in sometimes very important ways. Clients will be reluctant to share highly sensitive information which can have severe consequences for their therapy. I am hesitant to regularly tape sessions for this reason. We engage in therapy to meet the needs of the client. To tape for this purpose is to place a burden on our clients that is not about what they are in therapy for. Taping for training purposes is a necessary process, taping to test adherence is not, the same goal could be met through taping a staged session. Yes, it will be staged but I would argue in many cases the taped real sessions will be staged in a way as well.
- My primary reluctance is the change it creates in individual therapy for the client; my experience is that the session loses significant value when any recording device is present.
- As indicated above, client concerns about privacy are my biggest concern.
- Clients' reluctance to having the sessions video recorded has contributed to my reluctance.
- Many of my clients do not want to be video recorded and I do not want to push the issue with them.
- I wouldn't want to do it with a client who is against it or even passively against it.

- I am not reluctant at all unless the client is reluctant.
- Client's decline even audio taping. I'm willing to audio or video.
- I am not reluctant to video tape; however, any reluctance I have is related to client not wanting to be video-taped and is highly opposed to having sessions taped.
- Client comfort - many report that this would make them uncomfortable and I am concerned it may become a therapy interfering factor.
- The possibility of clients requesting to view or have a copy of the sessions.
- Concerns related to releases required for this form of sharing information. Concerns if legal proceedings occur if video could be subpoenaed.
- My ability to keep client's confidentiality.
- If video-taping impacts the quality of therapy for my client. I have my client's interest in mind and don't want them to feel uncomfortable.
- I do not have an issue with video recording as I appreciate the feedback. However, if I had a client who was concerned about their confidentiality I would discuss this at the DBT consultation group and take this on a case by case basis.
- Clients have reported it being a big distraction to the therapy session that they are paying for feeling a need to perform or end up self-sabotaging and feeling shame.
- In my experience, informing clients of video recording sessions can cause them to feel unsettled about their privacy and what is being done with the recording behind closed doors. Some clients have expressed paranoia that the information recorded could be held against them or that people may be laughing at their

problems. The concern typically reduces after a relationship is built but it can detour clients that are not fully committed to treatment.

- It seems clients are more reluctant to be videotaped if they have to be on camera. If we could only do voice recording and not have the client's face on the video tape I think we would have higher compliance.
- Axis II clients can be quite sensitive to changes in therapy environment. If client is uncomfortable, I may get distorted information from them.
- My biggest concern is that the client will not feel comfortable and the session will be unauthentic.
- We choose one to three client's to record a year and when the client makes a request to not record a session I honor that. I find client's that agree to recording are very willing to outside of when they are being affected by personal concerns. Typically, at these times they are experiencing intense sadness, loss or shame. Two clients mentioned at the end of the session they would have been self-conscious and not have been able to disclose like they did if the camera was on. One time I chose not to record as I was sick and it landed up being a good session for the client. In the future I likely will record.

- It's not part of standard protocol at my agency. It rarely happens as part of the team.
- My own issues regarding my body image. It is difficult to see myself on camera and that makes me somewhat reluctant to video record. Additionally, perfectionism can get in the way.

- Performance anxiety.
- Honestly, it just feels a bit awkward to see oneself on a screen. Perhaps I'm experiencing some emotional vulnerability, so I apply my DBT skills to reduce my vulnerability and I video tape anyway.
- Insecurity about my lack of experience and training and having others' view my tapes. I value feedback and know it would greatly inform me to work more effectively with clients. I would be less reluctant if I'm visually able to see others' examples of adherent and non-adherent therapy sessions prior to video-taping my own.
- Self-conscious and don't like being video-taped for anything. The idea of watching myself is much more uncomfortable than knowing others will watch it.
- I feel more uncomfortable in any setting when being video recorded so it may impact my effectiveness.
- I think the biggest hesitation comes from not having done it before. Once I do it, I believe it will get easier. What holds me back from doing it is that is just isn't something our team is doing...we talk about needing to do it but it just hasn't happened. Likely for all the reasons you list in your survey!
- Insecurity
- Don’t like watching myself
- When I know I am being videoed, I am concerned that I am more worried about doing my therapy according to DBT protocol rather than being totally attentive to the client's therapeutic needs.

- I just started providing DBT individual and group therapy and only have a handful of clients in the beginning stages of individual therapy.
- Feel like so many things to not forget/to cover adherently
- Conflict with members of consultation team.
- Team support of the use of video recording.
- I have never seen anyone actually performing DBT therapy through a video recording besides the main people who developed the program. I do not feel skilled in conducting DBT sessions at this time and only see one person on an individual basis for DBT therapy at this time.
- I get anxious about my peers watching me.
- My own anxiety about interpreting feedback as an indication I'm not doing well - and I understand that's not totally true.
- Fear of judgment or client disapproval.
- I believe there is a shame trigger for me, where my doubts of my abilities keep me from being fully confident in what I do; there is a fear that I'm going to be told I am doing it "wrong."
- At this point, for the number of times (4x/year for 2-3 years) I have video recorded, I have not received feedback as to how I'm doing directly related to the videos. This contributes to my reluctance to keep doing it.
- Judgments of the team when they view the video.
- Being told I am not doing it right and fearing my agency will have billing issues as a result and discipline me.

- Receiving feedback/criticism
- Wanting to know that I am following the model, however if I'm not it is hard to be vulnerable with a group of therapists who I have respect for. I think we all want to do right by clients and this is a good way to check to make sure we are, and it makes us vulnerable.
- Helpful feedback from the people viewing the recording.
- Please note I have done audio recordings of my Individual DBT sessions. The determining factor regarding reluctancy is whether or not the reviewer is fair, validating, and overall encouraging in their critique.
- Expressions from other team members about how they find reviewing taped sessions not useful.
- It is hard to make yourself vulnerable to others, and with that said, the exposure of doing so opens you up to valuable learning opportunities and gets easier over time
- a) Performance anxiety, b) Other consultation team members have not videotaped, c) I don't think our team has much skill/training in rating adherence, and d) Our team is pretty content with the status quo.
- I forget to prepare ahead of time and get the video equipment from the office manager's office.
- Getting access to equipment was a problem before I got Vidyo on my laptop. Dealing with the technical aspects of setting up the recording takes some time and attention I would rather spend with the client.

- It takes time to set up video equipment and change tapes when recording is full, which is my only current barrier to taping all sessions. I do find taping sessions to review during supervision very helpful.
- Technical issues, time-consuming, may be a distraction from the therapy being provided, and not everyone is doing it.
- I don't know if we are set up to video record and I don't have much interest in technology.
- Remembering to record sessions, setting up the physical environment to record effectively, and not having time to review sessions in supervision or in consultation team meetings are all barriers for me, personally.
- I'm open to it and think it is a great idea. The only problem that comes to mind is how to find the time to review team members recording along with other issues related to time and meeting my organizations productivity requirements and obtaining productivity hours for DBT related video recording needs.
- Primary concern is the issue of therapy and the need to focus on the client's treatment needs and not my own needs.
- Time, technology, overwhelmed with other tasks--takes extra effort. I desire to record them, but haven't prioritized the necessary steps to change my behavior.
- My biggest hesitation is bringing it up to my client and managing their resistance and needing to spend therapy time to prepare them to video-taped. Then there is the technology piece that never goes well. The recording did not work or was not loud enough and then having to ask the client again to record a session.

- Client feeling unwilling to do it, feeling that another professional would judge me harshly and without non-judgmental intent, I hate having to see my aging self on the screen--what a downer.
- Inadequate or nonexistent equipment in our agency and concerns that it might inhibit client's participation.
- The overall interference with therapy sessions and client's concern regarding confidentiality.
- Old age, lack of participation in video recordings.
- Technical challenges as a sole provider, concerns about feedback, lack of motivation as being considered a provider by state of MN has not yielded ANY benefits. Frustrated by hoops required by state with no increase in pay for DBT.
- Our team is continuing to meet DHS requirements and DBT adherence standards-- sometimes other administrative issues (transitioning to electronic forms throughout the clinic, maintaining consult consistency and adherence, and other challenges). It is difficult to fit it all in and know how to prioritize effectively while making client care primary. It's a work in progress. :)
- We have a team of 12 providers plus three interns. Each week we review as a team one video-taped session by one of our providers. Everyone presents a taped session before we begin the next 'round' of taping sessions. We have one video-recorder for the clinic.
- The hassle of finding/getting a camera and setting it up in my office. The change in dynamics of therapy with the client who is concerned about being on camera.

- I don't have a video camera and don't know if my agency has one, and if they do, I don't know if I know how to use it. I also don't know what paperwork I would have to have the client sign to use the video recorder, and it would take me time I don't feel that I have to figure out what how to use the recorder and how to ensure that the client has signed the appropriate paperwork to make it ok. And I don't know how the client would feel about it, and how to use it without lowering trust with the clients, who typically have very poor trust. Also, I don't have any extra funds to purchase video equipment at this time.
- Recording materials- agency either doesn't have them, or gaining access takes an act of Congress to get them. Secondly, it's just a matter of comfort and practice. I know if I did it more, it would reduce the reluctance I currently have. I am confident I could address client issues with my clients re: privacy, etc.
- Need Additional Training, Limited Technology.
- Primarily, I worry that my clients will be inhibited and therapy may not be as effective.
- The impact that having video recording equipment may have on my clients' therapy experience. Some, while voicing their permission to tape, have stated that they altered their behavior due to the process. Their well-being comes first, and taping is a distant second.
- Not having the equipment to record or play sessions, client's not feeling comfortable recording.
- Knowledge of how to work technology and keep HIPPA compliant.

- Personal cost, potential resentment at increasing requirements/demands of DBT/limits.
- The actual set up of the equipment. Time and client's reluctance.
- Finding time for review of tapes; concerns about client reluctance; cumbersome process at this agency.
- Lack of time; Burnout.
- Client's concerns about privacy and individual insecurities about feedback
- My main concern with video recording is the client's ability to experience privacy and being comfortable with being recorded. I would not want the videotaping to interfere with individual sessions. It has been my experience that reviewing video tapes is extremely valuable to professional development. Sometimes videotaping is a challenge due to accessibility to the equipment.
- The time it takes to schedule the video equipment, set up the equipment. Extra step with client in getting their agreement and it does impact session at times.
- I do not like setting it up and it all takes extra time to send the video to where it needs to go. Our agency has high expectations of seeing as many clients as possible.
- These responses refer to taping DBT skills group. I do not do individual DBT therapy.
- I wish there had been an N/A option. I do not have a non-DBT supervisor. We actually do not have video recording capabilities in our agency, so the answers I have given pertain to the use of a digital recorder. The agency does not have

enough of them, so they are stored in a secure area. By the time I think "Oh, I should record this," the session is already in progress. I and a couple other coworkers had been really good about recording earlier on, but there were other team member(s) who did it only once or not at all. I can imagine the inconvenience of obtaining and setting up video equipment, specifically considering the set-up of my office, so I think that would also be a hindrance. I certainly see the benefits of recording sessions, and I am thankful to have had the opportunity to do so. The feedback I have received from my team has been invaluable.

Appendix J: Literature Search

Literature Search: Databases Searched
Academic Search Premier
Africa-Wide Information
Alt HealthWatch
America: History & Life
American Bibliography of Slavic and East European Studies
Anthropology Plus
Applied Science & Business Periodicals Retrospective: 1913-1983 (H. W. Wilson)
Applied Science & Technology Full Text (H. W. Wilson)
Art Full Text (H. W. Wilson)
Art Index Retrospective (H. W. Wilson)
ATLA Catholic Periodical and Literature Index
ATLA Religion Database with ATLASerials
Avery Index to Architectural Periodicals
Bibliography of Native North Americans
Biography Reference Bank (H. W. Wilson)
Business Source Premier
CINAHL Plus with Full Text
Communication & Mass Media Complete
Consumer Health Complete—EBSCOhost
eBook Collection—EBSCOhost
EBSCO MegaFILE
Education Full Text (H. W. Wilson)
Education Index Retrospective: 1929–1983 (H. W. Wilson)
ERIC
Essay and General Literature Index (H. W. Wilson)
Film & Television Literature Index with Full Text
Fish, Fisheries & Aquatic Biodiversity Worldwise
Funk & Wagnalls New World Encyclopedia
Garden, Landscape & Horticulture Index
GreenFILE
Health Source—Consumer Edition
Health Source: Nursing/Academic Edition
Historical Abstracts
Humanities & Social Sciences Index Retrospective: 1907–1984 (H. W. Wilson)
Index Islamicus
Index to Jewish Periodicals
Index to Printed Music
International Bibliography of Theatre & Dance with Full Text
Left Index
LGBT Life with Full Text
Library Literature & Information Science Full Text (H. W. Wilson)

Library, Information Science & Technology Abstracts
MAS Ultra—School Edition
MasterFILE Premier
Mental Measurements Yearbook with Tests in Print
Middle Search Plus
Music Index
New Testament Abstracts
Old Testament Abstracts
Philosopher's Index
Primary Search
Professional Development Collection
Race Relations Abstracts
Readers' Guide Retrospective: 1890–1982 (H. W. Wilson)
Regional Business News
RIPM—Retrospective Index to Music Periodicals
RISM Series A/II: Music Manuscripts after 1600
Science Reference Center
SPORTDiscus with Full Text
Textile Technology Index
The National Review Archive
The New Republic Archive
Wildlife & Ecology Studies Worldwide
Women's Studies International
The Nation Archive Premium Edition
Chicano Database
Index to 19th-Century American Art Periodicals
History of Science, Technology & Medicine
AHFS Consumer Medication Information
Public Administration Abstract